ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672

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population, and the resources available.[25] There are two levels that the education component must simultaneously address - the education system through the local school districts, and the community at large.

ANCADA is already working on a plan to train the RTA's to give teacher workshops on the use of the Seattle school disctict alcohol education curriculum entitled "Here's Looking At You". This curriculum is designed to be used from kintergarden to 12th grade and provides information as well as suggestions on presenting the curriculum in the classroom. A letter from Diane Le Resche, State Department of Education, was mailed to all school districts in April 1977 explaining the curriculum and where the curriculum could be obtained. By training teachers in the region this next year to use the curriculum, one would easily be able to measure how many school district's actually have begun using the curriculum.

Community education sessions have been taking place in the region but on an informal and sporadic basis. Funds would be needed to hold community education workshops in the region. These workshops would be mainly a listing of all the available resources and a presentation of 1 or 2 sample community education presentations with emphasis on group role playing participation. It has been my feeling over the past several months that the main problem with community education services to date has been the individual's uncomfortableness in speaking to groups. The Outpatient/Education Coordinator would be responsible for providing this training, and for maintaining a resource bank of educational materials for the region.

## V. CONCLUSIONS

This paper has been an effort to show how a comprehensive regional Indian alcoholism program can be operational under the already existing structure of the Southeast Alaska Regional Health Corporation. I have tried to identify some of the issues that need to be resolved prior to initiation of such a program, the program options available, and finally a detailed explanation of one recommended program option using the JCAH standards as a guideline. In this presentation, I have shown that several of the components now already exist within the Health Corporation. What needs to be done is to begin tying together what already exists. Although the program will operate under the SEARHC organizational structure, it is absolutely essential that the alcoholism service components be seen as one identifiable program under SEARHC not only to the community and potential clients, but to the agencies that the program will be working with.

This tying together of already existing components also makes it easier to identify gaps of service. I think one of the problems in the past has been that services have been so fragmentary leading to a false impression that nothing has been offered. Also, publicly identifying a comprehensive program will make it easier for the program to apply for and receive funds from other sources. Any funding body needs to see a plan of action, including goals and objectives. By being able to show that the program has recognized the need to provide services in each of the components and has set up a time frame to accomplish this, this will give the potential funding body (be it NIAA, State Office of Alcoholism, etc.), a clear picture of the program's intentions.

One of the most essential points of the JCAH manual is documentation of what a program is doing. This paper is just the first step, giving hints for an organizational start up. The next phase would be to write program goals and objectives and a long range plan.

I can not overemphasize that before a regional alcoholism program can be initiated that it is absolutely essential that SEARHC re-examine the issues and program model options presented in this paper. What has been presented has been one individual's recommendations. Whatever program model adopted must reflect the policies and commitment of the SEARHC Board of Directors. Without that, any attempt to initiate any program will be a failure.

# APPENDIX ONE

## TABLES

TABLE ONE

Estimated Number of Indian Alcoholics
In SE Alaska*

| Population Source | Estimated SE Native Pop. | Estimated Number Alcoholics (9.2%) |
|---|---|---|
| 1970 Census** | 7,625 | 701 |
| ISEGR*** | 8,277 | 761 |
| ANCSA**** | 9,902 | 911 |
| BIA***** | 12,262 | 1,128 |
| BIA****** | 11,303 | 1,040 |

* Estimated percent taken from Allocation of Adult Alcoholics in Alaska By Geographic, Sex, and Racial Indices

** 1970 Census of Population, Volume 1, Part 3, Table 34

*** From Division of Economic and Social Development, Tlingit and Haida

**** From Division of Economic and Social Development, Tlingit and Haida

***** From Division of Economic and Social Development, Tlingit and Haida

****** From Staff Estimates of Native Alaskan Population, Labor Force, Employment and Unemployment By Agency With Area (State) Totals For Years 1966-1976, Bureau of Indian Affairs

TABLE TWO

Estimated Number of Problem Drinkers in SE Alaska*
Using Parker Marden Formula

| Age | Male | Female | Total |
|---|---|---|---|
| 0-19 | | | |
| 20-29 | 791.62 | 62.52 | 854.14 |
| 30-39 | 525.13 | 210.07 | 735.20 |
| 40-49 | 474.50 | 156.47 | 630.97 |
| 50-59 | 268.74 | 34.13 | 302.87 |
| 60-69 | 137.93 | 11.38 | 149.31 |
| 70+ | 8.64 | 2.14 | 10.78 |
| | 2,206.56 | 476.71 | 2,683.27 |

* Population figures from 1970 Census statistics; Computation Worksheets On File in RTA office

TABLE THREE

Estimated Percent: Native Population
Of Total SE Population Using 1970 Census Data

| District | Total Pop. | Native Pop. | % Native of Total Pop. |
|---|---|---|---|
| Angoon | 503 | 371 | |
| Haines | 1,504 | 315 | |
| Juneau | 13,556 | 1,477 | |
| Ketchikan | 10,041 | 1,179 | |
| Otr. Ketch. | 1,676 | 820 | |
| Pr. Wales | 2,106 | 567 | |
| Sitka | 6,109 | 1,169 | |
| Sgw./Yak. | 2,157 | 752 | |
| Wrg./Ptrs. | 4,913 | 975 | |
| | 42,565 | 7,625 | .18% |

TABLE FOUR

Native Utilization of SE Alaska
Alcoholism Programs*

| Program | Total Native | Total Client | % Native |
|---|---|---|---|
| Juneau | 152 | 452 | |
| Ketchikan | 101 | 365 | |
| Sitka | 167 | 279 | |
| Petersburg | 107 | 169 | |
| Wrangell | 5 | 24 | |
| Yakutat | 103 | 109 | |
| Total | 635 | 1,398 | 45% |

* From 1976 State Office of Alcoholism Annual Report

# APPENDIX TWO

## TIME FRAME

# TIME FRAME
## SE Regional Indian Alcoholism Program

| FY78 | FY79 | FY80 |
|---|---|---|
| ESTABLISH:<br><br>1. Management/Support<br>a. Regional Coordinator & AA hired<br>b. Administrative & Case files<br>c. Fiscal management<br>d. Program plan, goals and obj.<br>e. Referral proc. & affil. agrmt.<br>f. Evaluation tools<br><br>2. Emergency<br>a. Detox policy and prcdrs.<br>b. Training for health aides<br>c. Affil. agrmt. with urban areas<br><br>3. Outreach<br>a. Identif. of alcoh. resources<br>b. Liason with comm. organizations<br>c. Referral policy and proc.<br>d. Training for outreach workers<br>e. Affil agrmt. with urban areas | ESTABLISH:<br><br>1. Inpatient<br>a. IHS contract: Alcoholism Therapy Services<br><br>2. Outpatient<br>a. Outpatient/Educ. Coord. hired<br>b. Affil. agrmt. with T&H Soc. Ser.<br>c. Grant to IHS or SOA for Outpatient Couns. positions<br>3. Aftercare<br>a. Training for outreach workers<br>b. Affil. agrmt. with urban areas | ESTABLISH:<br><br>1. Intermediate<br>a. Affil. agrmt with Halfway Houses<br><br>2. Education<br>a. Reg. Alcoh. Wrkshps.<br>b. Reg. Tchr. Wrkshps.<br>c. Resource Bank<br><br>3. Outpatient<br>a. Outpatient Counselors hired |

# APPENDIX THREE

## BUDGET

PROJECTED BUDGET
Regional Indian Alcoholism Program

| FY78 | Funds Available | New Funds | Total |
|---|---|---|---|
| Management/Support | 43,500 | 10,600 | 54,100 |
| Emergency Care | 14,500 | 16,000 | 30,500 |
| Outreach | 53,000 | 5,400 | 58,400 |
| Total FY78 | 111,000 | 32,000 | 143,000 |

| FY79 | | | |
|---|---|---|---|
| Management/Support | | 62,000 | 62,000 |
| Emergency Care | 20,000 | 21,200 | 41,200 |
| Outreach/Aftercare | 80,000 | 8,600 | 88,600 |
| Inpatient | 84,000 | | 84,000 |
| Outpatient | | 22,000 | 22,000 |
| Total FY79 | 184,000 | 113,800 | 297,800 |

| FY80 | | | |
|---|---|---|---|
| Management/Support | | 72,000 | 72,000 |
| Emergency Care | 21,000 | 21,200 | 42,200 |
| Outreach/Aftercare | 84,000 | 8,600 | 92,600 |
| Inpatient | 88,200 | | 88,200 |
| Outpatient/Education | | 61,000 | 61,000 |
| Intermediate | - | - | - |
| Total FY80 | 193,200 | 162,800 | 356,000 |

PROJECTED BUDGET
FY78
Regional Indian Alcoholism Program

| | Funds Available | New Funds | Total |
|---|---|---|---|
| Management/Support | | | |
| 1. Regional Alcoh. Coord. (Salary+Frnge: GS11) | 22,000 | 3,000 | 25,000 |
| 2. Administrative Asst. (Salary+Frnge: GS5) | 10,000 | 4,600 | 14,600 |
| 3. Consultant | | 3,000 | 3,000 |
| 4. Admin. Costs (Travel, Fac. Comm., Supplies, Other) | 11,500 | | 11,500 |
| Total | 43,500 | 10,600 | 54,100 |
| Emergency | | | |
| 1. Health Aides(1/8 time) | 14,500 | | 14,500 |
| 2. Detox Supervisors | | 12,000 | 12,000 |
| 3. Health Aide Trning | | 4,000 | 4,000 |
| Total | 14,500 | 16,000 | 30,500 |
| Outreach | | | |
| 1. Outreach Workers (1/2 time) | 53,000 | | 53,000 |
| 2. Outreach Training | | 5,400 | 5,400 |
| Total | 53,000 | 5,400 | 58,400 |

BUDGET JUSTIFICATION
FY78

1) Regional Alcoholism Coordinator. This position will be mostly covered by the ANCADA grant. As the position will be administrative rather than technical assistance, it is my feeling that this position should be filled at a GS-11/12 salary range. Possibly ANCADA will be able to budget for those funds.

2) Administrative Assistant. This position could be partially funded under the T&H Manpower CETA Title VI program. As the maximum salary for these positions is $10,000, I would recommend that additional monies be found to upgrade this position to a GS5/7 level as the duties require more responsibility than just clerical.

3) Consultant. It is my feeling that hiring a consultant from the Seattle Indian Alcoholism Program during the first year of operation would be highly valuable as the SIAP has been in operation since 1972, and has had to go through many of the organization problems that will face this program. Monies for this position were budgeted as follows:

4 one week program visits ($100 day program consult. x 5 days + $200 round trip air fare: Seattle = $700 per trip x 4 visits = $2800.

4) Administrative Cost. The major administrative cost for this program have already been figured in the ANCADA grant (this includes travel, facilities cost, communications, office supplies, etc.). What was not figured would be the additional office space needed for two individuals during the first year. However, what has already been budgeted will most probably be sufficient.

5) Health Aides. The Health Corporation presently has a contract with IHS for 10 full time aides, 4 1/2 half time aides, and 13 alternates amounting to $116,000. It is estimated that approximately 1/8 of the health aides time would be spent on the provision of detox services.

6) Detox Supervisors. Monies for these positions have been budgeted as follows:

$50 day x 3 days x 4 detox clients x 20 communities = $12,000.

It is estimated that each community on the average will detox 4 clients per year. Each client will be detoxed an average of 3 days. The part time detox supervisors will be paid $25 for a 12 hour shift.

7) Health Aide Training. Training monies will be needed for one 3 day in-service training workshop for the health aides on detox supervision. Monies for this training have been computed for 10 health aides to attend a 3 day workshop (1 day travel) in Sitka:

$2,000 (Transp. 10 indiv.) + $2,000 (Per Diem: 4days) = $4,000

The training will be provided either by the Regional Alcoholism Coordinator or the SEARHC Field Trainer. Monies are needed only for travel and per diem of health aides only.

8) Outreach Workers. The Health Corporation has a contract with IHS for 6 Outreach Workers and a contract with T&H Manpower for 6 more Outreach Worker positions amounting to approximately $106,000. It is estimated that approximately 1/2 of the outreach worker's time will be spent on the provision of alcoholism services.

9) Outreach Worker Training. Training monies would be needed for one 3 day (1 day travel) training workshop on the provision of outreach and aftercare services. Training costs have been computed as follows:

$3,000 (Transp. 12 indiv.) + $2400 (Per Diem) = $5400.

PROJECTED BUDGET
FY79
Regional Indian Alcoholism Program

| | Funds Available | New Funds | Total |
|---|---|---|---|
| Management/Support | | | |
| 1. Regional Alcoh. Coord. (Salary+Frnge:GS12) | | 32,000 | 32,000 |
| 2. Administrative Asst. (Salary+Frnge:GS6) | | 17,000 | 17,000 |
| 3. Admin. Costs | | 13,000 | 13,000 |
| Total | | 62,000 | 62,000 |
| Emergency | | | |
| 1. Health Aides(1/8 time) | 20,000 | | 20,000 |
| 2. Detox Supervisors | | 12,000 | 12,000 |
| 3. Health Aide Trning | | 9,200 | 9,200 |
| Total | 20,000 | 21,200 | 41,200 |
| Outreach/Aftercare | | | |
| 1. Outreach Wrkrs(1/2 time) | 80,000 | | 80,000 |
| 2. Outreach Training | | 8,600 | 8,600 |
| Total | 80,000 | 8,600 | 88,600 |
| Inpatient | | | |
| 1. ATS Contract | 84,000 | | 84,000 |
| Total | 84,000 | | 84,000 |
| Outpatient | | | |
| 1. Outpnt/Educ. Coord. | | 22,00 | 22,000 |
| Total | | 22,000 | 22,000 |

BUDGET JUSTIFICATION
FY79

1) Regional Alcoholism Coordinator. This position would be upgraded to a GS-12 and would remain at that level.

2) Administrative Assistant. This position would be upgraded to a GS-6 during the second year of operation.

3) Administrative Costs. Administrative costs would be increased by 12% to include administrative overhead for 3 positions.

4) Health Aides. The Health Corporation anticipates hat they will have 16 full time health aides by this fiscal year with an estimated total contract of $160,000. Health aides time in the provision of alcoholism services will remain at 1/8.

5) Detox Supervisors. This amount will remain the same pending evaluation as to how much is expended during FY78.

6) Health Aide Training. Continuing training monies for one 3 day training for 16 health aides is computed as follows:

| Trans. (16 indiv.) | + Per Diem (4 days) | |
|---|---|---|
| 6,000 | + 3,200 | = 9,200 |

7) Outreach Workers. The Health Corporation anticipates that they will have approximately 6 more outreach worker positions this fiscal year with a total estimated budget of approximately $160,000. The outreach worker's time in the provision of alcoholism services will remain at 1/2.

8) Outreach Training. Continuing training monies would be needed for one 3 day training workshop on the provision of outreach and aftercare services.

| Trans. (18 indiv.) | + Per Diem (4 days) | |
|---|---|---|
| 5,000 | + 3,600 | = 8,600 |

9) ATS Contract. The Alcoholism Therapy Services contract with IHS is presently being contracted to Sitka Alcoholism Council for approximately $84,000. This amount includes approximately 3 1/2 staff positions.

10) Outpatient/Education Coordinator. This would be a new position which would work out of the regional office, and would be responsible for coordinating services for both the outpatient and education components.

PROJECTED BUDGET
FY80
Regional Indian Alcoholism Program

| | Funds Available | New Funds | Total |
|---|---|---|---|
| Management/Support | | | |
| 1. Regional Alcoh. Coord. (Salary+Frnge: GS12) | | 33,000 | 33,000 |
| 2. Administrative Asst. (Salary+Frnge: GS7) | | 19,000 | 19,000 |
| 3. Administrative Costs | | 20,000 | 20,000 |
| Total | | 72,000 | 72,000 |
| Emergency | | | |
| 1. Health Aides(1/8 Time) | 21,000 | | 21,000 |
| 2. Detox Supervisers | | 12,000 | 12,000 |
| 3. Health Aide Trning | | 9,200 | 9,200 |
| Total | 21,000 | 21,200 | 42,200 |
| Outreach/Aftercare | | | |
| 1. Outreach Workers | 84,000 | | 84,000 |
| 2. Outreach Trning | | 8,600 | 8,600 |
| Total | 84,000 | 8,600 | 92,600 |
| Inpatient | | | |
| 1. ATS Contract | 88,200 | | 88,200 |
| Total | 88,200 | | 88,200 |
| Outpatient/Education | | | |
| 1. Outpnt/Educ. Coord. (Salary+Frnge:GS11) | | 25,000 | 25,000 |
| 2. Outpnt. Counselors (Slary+Frnge:GS7) | | 36,000 | 36,000 |
| Total | | 61,000 | 61,000 |

BUDGET JUSTIFICATION
FY80

1. Regional Alcoholism Coordinator. This position would remain at GS12, Step One.

2. Administrative Assistant. This position would be upgraded to a GS7.

3. Administrative Costs. Administrative costs would be increased to $20,000 and include administrative overhead for 5 positions.

4. Health Aides. The Health Corporation anticipates continuing 16 full time health aides. An increase of a minimum 5% salary increase is projected with the health aides continuing at 1/8 time.

5. Detox Supervisers. Same

6. Health Aide Training. Same

7. Outreach Workers. The Health Corporation anticipates maintaining 18 outreach worker positions. Increase is for a minimum 5% salary increase.

8. Outreach Training. Same

9. ATS Contract. 5% increase.

10. Outpatient/Education Coordinator. This position would be upgraded to a GS11

11. Outpatient Counselors. Monies are for two outpatient counselors beginning at GS7.

# APPENDIX FOUR

## JOB DESCRIPTIONS

TITLE: Regional Alcoholism Coordinator

SALARY RANGE: $22,000-26,000 (GS11/12)

BASIC FUNCTION: To act as a program coordinator for a SE Regional Indian Alcoholism Program.

SPECIFIC DUTIES:

1) To set up necessary management support systems including administrative and client files, referral procedures, fiscal management policies, and evaluation mechanisms.

2) To write an annual program plan including goals and objectives under supervision of SEARHC Board of Directors.

3) To provide information and technical assistance to communities and local alcoholism programs including program development, grant application procedures, and fiscal management policies.

4) To act as liason with community and regional service agencies in providing coordinated alcoholism services.

5) To negotiate and sign affiliation agreements with agencies providing services not covered in regional alcoholism program.

6) To plan and set up alcoholism training programs for SEARHC staff and community groups

7) To seek supplemental sources of funding for comprehensive alcoholism program delivery.

REQUIRED KNOWLEDGE AND SKILLS:

1) Good administrative background including knowledge and experience in office procedures, accounting and grant managment. At least 4 years administrative work experience.

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values. Preferably 2-3 years direct work experience in an alcoholism program.

3) Ability to set up workable program plan, goals and objectives, meet time frame, make administrative decisions, and delegate work responsibility.

4) Ability to set up appropriate training programs and provide in-service training to SEARHC staff.

TITLE: Administrative Assistant

SALARY RANGE: $12,500-$15,500 (GS5/7)

BASIC FUNCTION: To provide administrative backup to the Regional Alcoholism Coordinator

SPECIFIC DUTIES:

1) To maintain administrative files and confidential patient case files.

2) To set up and maintain in conjunction with the Health Corporation Comptroller appropriate accounting procedures for alcoholism program

3) To assist in the draft preparation of reports and correspondance of the Regional Alcoholism Coordinator

4) To type all necessary reports as assigned by the Regional Alcoholism Coordinator.

5) To assist in the preparation of regional alcoholism workshops including travel arrangments, preparation of training materials, and registration.

6) To prepare monthly statistical reports on program operation.

7) To purchase all supplies for program.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum of 3 years general office experience including one year administrative and accounting experience.

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values. Preferably 1 year direct work experience in an alcoholism program.

3) Ability to perform a number of varied responsible work tasks under prescribed time frames.

4) Ability to compose draft correspondance, minutes and reports.

TITLE: Outpatient/Education Coordinator

SALARY RANGE: $19,000- $23,000 (GS9/11)

BASIC FUNCTION: To supervise regional outpatient staff and to direct a comprehensive education program in.SE Alaska

SPECIFIC DUTIES:

1) To supervise regional outpatient staff.

2) To be responsible for updating regional client files, for writing social/psychological evaluations, and for maintaining confidentiality of files.

3) To maintain client tracking system.

4) To maintain resource bank of educational materials for use in region.

5) To set up and provide regional community education workshops.

6) To provide teacher workshops on utilization of Seattle alcohol education curriculum.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum of two years supervisory experience preferably in alcoholism program.

2) Preferably at least one year work experience as an instructor or trainer.

3) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values.

4) Ability to write appropriate training materials for region.

TITLE: Regional Outpatient Counselor

SALARY RANGE: $16,000 - $19,000 (GS7/9)

BASIC FUNCTION: To provide outpatient counseling services.

SPECIFIC DUTIES:

1) To provide individual and group counseling to individuals with alcohol abuse problems and to their families.

2) To utilize the cottage program group technique.

3) To travel to surrounding rural communities on a regular basis to offer outpatient services.

4) To consult with health aide and outreach worker staff.

5) To make appropriate referrals.

6) To write treatment plans and progress notes.

REQUIRED KNOWLEDGE AND SKILLS:

1) Minimum 3 years counseling background (at least one year in alcoholism program).

2) Knowledge and understanding of alcoholism with particular emphasis on Indian culture and values.

3) Ability to work closely with native client groups.

FOOTNOTES

1. Leland, Joy. Firewater Myths (Rutgers Center of Alcohol Studies: 1976), pp. 10-15.

2. Accreditation Manual For Alcoholism Programs (Joint Commission On Accreditation of Hospitals:1974), p. 3.

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6. A Procedure For Estimating the Potential Clientele of Alcoholism Service Programs (Division of Special Treatment and Rehabilitation Programs, NIAAA .

7. Census of the Population: 1970 (Bureau of the Census), Table 35.

8. Census of the Population: 1970 (Bureau of the Census), Table 34.

9. 2(c) Report: Federal Programs and Alaska Natives Introduction and Summary, Task 1, Part B, Section 1, p. 71.

10. State Office of Alcoholism Annual Report 1976.

11. Turner, Fain, and Kauffman. Analysis of an Indian Alcoholism Program, A Case Study. (Unpublished Paper of Seattle Indian Alcoholism Program).

12. Lewis and Ho. "Social Work With Native Americans". Social Casework (September 1975), pp. 379-389.

13. American Indian Alcohol Project Grant(Southeast Alaska Regional Health Corporation Grant to NIAAA), Problem Statement.

14. JCAH, p. vii.

15. JCAH, p. xii.

16. 1977 Annual Update to Alaska State Plan, p.3.

17. JCAH, pp. 9-23.

18. JCAH, pp. 35-40.

19. JCAH, pp. 53-58.

20. JCAH, pp. 41-44.

21. JCAH, pp. 53-58.

22. JCAH, pp. 63-68.

23. JCAH, pp. 47-52.

24. JCAH, pp. 69-70.

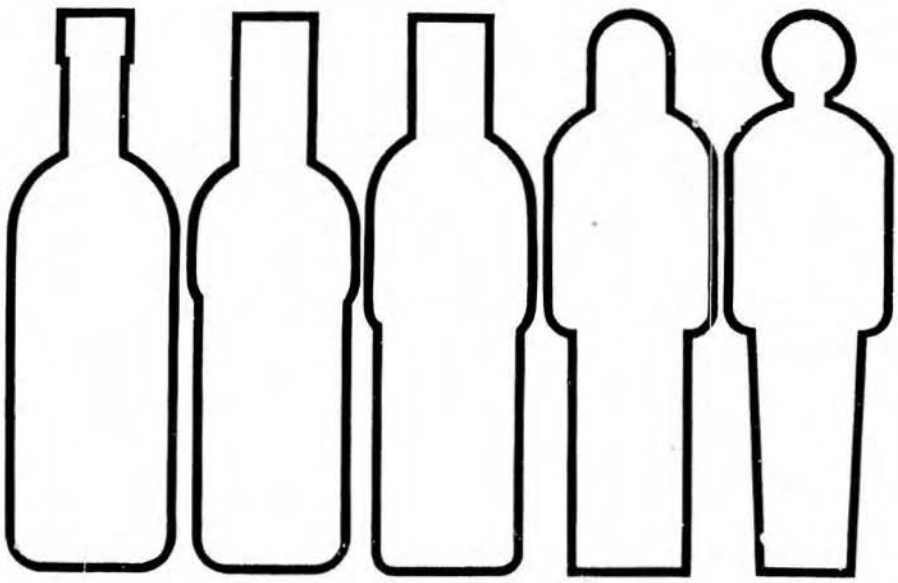
25. JCAH, pp. 71-73.

SCOMM

#6:30

# ALCOHOL ABUSE PROGRAMS IN CITIES:

## Strategies Applied



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**Appendices**

# *PREFACE*

Three years ago, the U.S. Conference of Mayors (USCM) determined that the social costs of alcoholism and alcohol abuse were exacting too high a toll among cities and resolved to give special attention to this critical urban problem. In order to determine the most relevant course of action, the appropriate policy committees and an advisory committee comprised of knowledgeable mayors were asked to take this issue under consideration. They were to determine the best means for the Conference to bring its resources to bear upon this problem. The mayors recommended the following:

Phase 1) survey a sample of cities to determine local alcohol needs and priorities;
Phase 2) develop information for mayors on available resources and strategies to use in coping with alcohol abuse; and
Phase 3) apply the recommended strategies in pilot cities.

With the strong support and encouragement of the National Institute on Alcoholism and Alcohol Abuse (NIAAA), the USCM has implemented the above recommendations. This publication describes the third and final phase, the applied strategies in pilot cities.

Ten pilot cities were selected on the basis of the leadership that the mayors would be able to exert in the development of alcohol services and the local need for development and/or expansion of these services. Regional distribution and varied population size were also selection factors. Regional meetings were held with personnel in the selected cities to discuss strategies and to develop individual work programs.

The primary purpose of the pilot cities phase was to demonstrate the impact that mayors can have upon developing resources for planning, coordinating, and administering alcohol abuse services. Additionally, many of the prevention, treatment, and rehabilitation strategies developed for cities by USCM in Phase 2 have been applied in these pilot cities. Thus, these general approaches to alcohol services are discussed and analyzed in relation to the individual economic, legal, political, and social circumstances of each city.

# *EXECUTIVE SUMMARY*

THE EXTENT OF THE PROBLEM

Nearly 70 percent of all adult Americans drink alcoholic beverages. Problem drinking exists at all socioeconomic levels. An estimated nine million Americans can be classified as alcoholics. For every alcoholic, an additional four persons are affected. In recent years, the incidence of alcoholism has been increasing rapidly among women and young people. Rehabilitation programs tailored to these groups are needed in many communities.

THE COSTS OF ALCOHOL ABUSE

Alcohol abuse and alcoholism cost the nation some $25 billion annually, and much of the financial burden is borne by local governments. Of special concern to local officials are: the drunk driver; the public inebriate; the alcoholic employee; and the criminal with alcohol-related problems.

ORGANIZATION OF THE USCM PILOT CITY PROGRAM

The pilot city programs were implemented to test the strategies developed earlier by the USCM Alcohol Abuse Project to assist cities in addressing the costs and social tragedies associated with alcohol abuse. These strategies were described in an earlier USCM publication, *Alcohol Abuse Programs in Cities: Strategies for Mayors.*

The Mayor selected a Lead Program area, e.g., public inebriate, drinking driver, etc., upon which to concentrate initially which would yield short-term benefits, and also would provide the initiative for expansion of existing services.

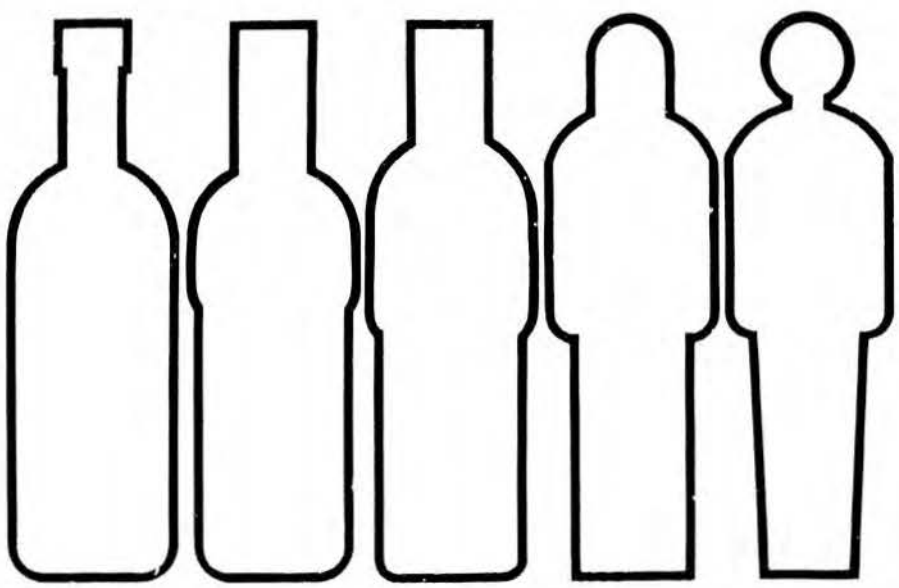
An integral part of establishing the Lead Program concept was the individual Work Program. This mechanism provides the mayor with an important tool for future review and analysis. Quantifiable activities have been developed for each component which include: identification of the elements, goals, and objectives; action steps and responsibilities; resources; and time frames for the various tasks undertaken.

## RECOMMENDED APPROACHES TO THE LEAD PROGRAM CONCEPT

In order to assure a solid foundation for the future expansion of the Lead Program into a comprehensive system of alcohol services, mayors are encouraged to select an initial approach that holds promise for a high rate of success in their communities. If the first major effort is productive and effective, there will be community support and commitment for the development of additional alcohol services. Basic approaches can be:

- Coordination—Example: Appointing an interjurisdictional task force comprised of members from the public and private sectors to integrate and maximize existing services and resources.
- Employee Assistance Program—Example: Establishing a means to refer city employees with drinking and/or personal problems to treatment and counseling services.
- Public Inebriate Program—Example: Providing treatment and rehabilitation services outside the criminal justice system for indigent inebriates.
- Public Education Program—Example: Promoting media campaign through the local alcohol council to publicize the symptoms of alcoholism and the treatment services available.
- Driving While Intoxicated Program—Example: Establishing a system to treat and rehabilitate drinking drivers with the back-up of fines, suspension of licenses, and possible incarceration.

# CHAPTER I: ORGANIZATION OF THE PILOT CITY PROGRAM



Regional technical meetings, attended by Alcohol Abuse Project staff and target cities' planners, produced a framework for target cities' participation in the Pilot Cities Program. City goals were identified clearly and steps toward achievement were mapped out through development of work programs and selection of a lead program.

## WORK PROGRAMS

### Rationale

Work programs were developed as a means to identify the needs of the cities and the process necessary to address those needs. It was believed that a work program format would be most likely to encourage full utilization of available resources, identification of system gaps, and eventual creation of an appropriate, comprehensive, and coordinated alcohol abuse services network.

The work program mechanism offered a tool for future review and analysis of the project's impact. Built into each work plan were quantifiable activities which later would facilitate assessment of the system design and examination of the extent to which the system met its goals.

A third appealing aspect of the work program was that in its development it provided a forum for a diverse group of city planners to share ideas and enumerate steps toward a mutual goal. Moreover, creation of a work program provided evidence of a spirit of cooperation at an early stage in the development of a city's alcohol abuse program.

### Design

Detailed in each city work program were several key service components: Elements; Goals and Objectives; Action Steps/Responsibility; Resources; Time. (See Appendix B for sample.) Spelled out in the Elements subsection were those features of a program which would affect the short-range program goals. For example, this group might include some or all of the following: creation of a mayor's coordinating committee; development and distribution of a public policy statement; and a local assessment. Products of such elements might, in turn, include: establishment of a forum for developing approaches to alcohol abuse problems in the city; establishment of a city administrative policy and public health policy; and the gathering and analysis of supportive data.

The Action Steps/Responsibility breakdown focused upon accomplishment of intended results. Continuing with the previous illustration, steps toward establishment of a forum for developing approaches to city alcohol abuse problems might begin with submission of a request to the mayor for the creation of a coordinating committee. A needs analysis could be conducted, for example, by defining the alcoholic population, taking an inventory of resources, and assessing federal, state, and local resources and policies.

Resources were selected from an extensive array of local, state, and national possibilities. Included in this category were the expertise of individuals representing: local health, manpower, and criminal justice departments and agencies; State Alcohol Authorities; local volunteers; the USCM Alcohol Abuse Program (AAP) staff; etc.

Time, the final item of the work program was the most straightforward of all categories. Dates were targeted for completion of the identified tasks. This included both the final date for achievement of the objective plus the length of time necessary to reach that final date.

Work programs for each city were drawn up through the joint efforts of the city's planners and USCM AAP staff. The USCM preliminary survey of local alcohol abuse problems had identified general problem areas posing a challenge to cities. The seriousness of these problems was confirmed by city planners. Confirmation of the problems in combination with the local perspective afforded by city planners enabled the city planners and USCM AAP staff to develop a work program and select a major problem area to be addressed—the lead program.

## THE LEAD PROGRAM

The lead program, so termed because it was both the kick-off for and a microcosm of, each city's potential alcohol abuse program, identified a specific area which, in the short run, would be benefited most by the city's attention. In effect, lead programs were components of a full scale comprehensive alcohol abuse delivery system, but they were designed to be small scale, comprehensive systems in and of themselves. They were constructed to be goal-oriented and targeted to one or more specific populations such as: the troubled employee; the public inebriate; the drunken driver; and/or specific tasks such as prevention or public education.

As envisaged, lead programs would be the first in a series of comprehensive mini-programs which, when combined, would form an omnibus program of alcohol abuse services for the city. At different stages of lead program development, various results were anticipated. Initial discussion of the programs was expected to generate cooperation among the local government and private agencies, forming the core of any comprehensive system which finally would emerge. As one lead program was planned and implemented, it was expected that the city would be able to begin planning for implementation of another lead program, thus building an extensive delivery system on a component basis.

The lead program concept was particularly attractive as components could be designed to fit within a city's current fiscal constraints. The approach allows a city to move into the project on an incremental basis, addressing the most acute problems immediately and adding to the system as additional resources become available.

Having once identified specific lead programs, it was possible for the USCM AAP staff to focus its technical assistance on and provide specific information and resource materials to the target cities for implementation of the lead program.

The majority of target cities chose a single lead program. During work programming sessions, several cities opted to select a secondary lead program as well. For the most part, there was little deviation from the planned work program; any modifications which did take place occurred in instances where lead programs were expanded through inclusion of additional elements.

Planners in Bridgeport, Conn., proposed to adopt the lead program of Coordination. Selection of this particular program was based upon the planner's growing recognition of alcohol abuse problems and the consequent need for appropriate services. Although a number of resources could be named, they had neither been systematically collected nor analyzed in respect to the degree to which they served community requirements. Furthermore, because of this situation, it was difficult, if not impossible, to gauge the need for possible changes in the services system. Thus, prior to embarking on the Coordination lead program, planners believed it prudent to undertake first a needs assessment and compile an inventory of resources.

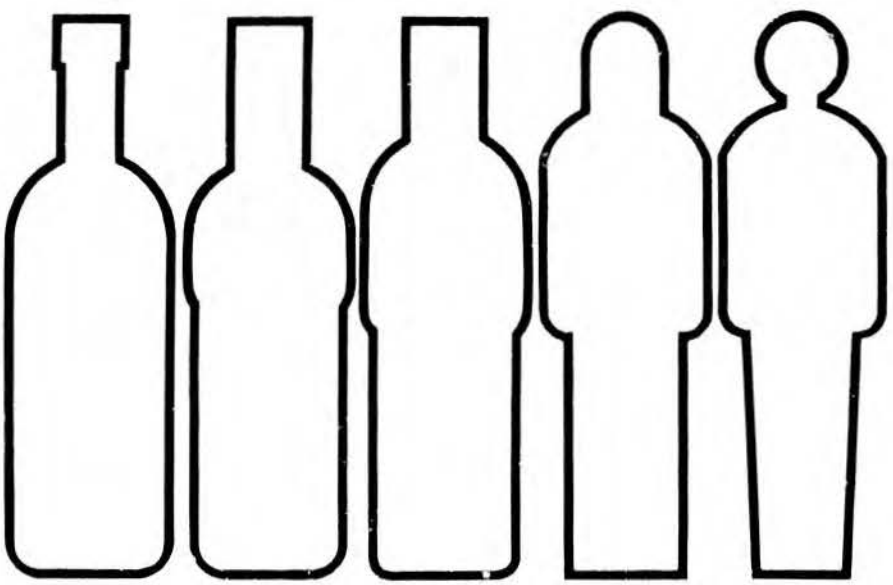
In performance of these preliminaries, there emerged a clearer picture of local services and community *wants*. While coordination remained the foremost objective, it became evident that coordination was not reasonable without concurrently developing an aggregate system. Gaps in services had to be filled, greater dialogue and information with state and federal officials had to be initiated, and newly identified resources had to be tapped before being included in the system.

Aside from adding a new dimension to the coordination lead program, implementation of the Action Steps/Responsibility component produced a second, somewhat unexpected, albeit well received, result. New awareness and interest in alcohol abuse problems led to exploration of new aspects of the disease and the introduction of several complementary lead programs.

An employee assistance program was created to serve municipal employees. A public education program was launched which encouraged several related efforts. A by-product of alcohol abuse seminars which were attended by the medical community was recognition of the pressing need for a Public Inebriate Program. This, in turn, led to a mayoral decision to organize a citizen representative Mayor's Task Force charged with examination of the problems of alcohol abuse in general and the public inebriate in particular.

In effect then, the Bridgeport effort epitomizes the lead program concept. Building blocks of a comprehensive system were constructed individually and molded together to form a larger, more complete whole.

# *CHAPTER II: APPROACHES TO THE LEAD PROGRAM CONCEPT*



While approaches to lead program implementation varied from target city to target city, the program construction remained fairly constant.

## THE EMPLOYEE ASSISTANCE PROGRAM

A majority of the participating cities chose to begin their alcohol abuse project efforts by establishing an Employee Assistance Program (sometimes referred to as an occupational alcoholism program) for city workers. A number of reasons accounted for selection of the Employee Assistance Program.

For one, the proximity and well-defined boundaries of the program made it manageable. Due to the in-house characteristic of the Employee Assistance Program, planners were in a position to create, oversee, and direct program activities.

Equally important was the fact that the decision to offer an Employee Assistance Program was a demonstration of good faith. Local officials were not only calling for abstract changes by and within the community. They were choosing to pay personal attention to the problem by offering services to city employees in recognition of alcoholisms' pervasiveness, its mammoth human and financial toll, and, most significantly, the potential for recovery from alcoholism.

### Program Intent

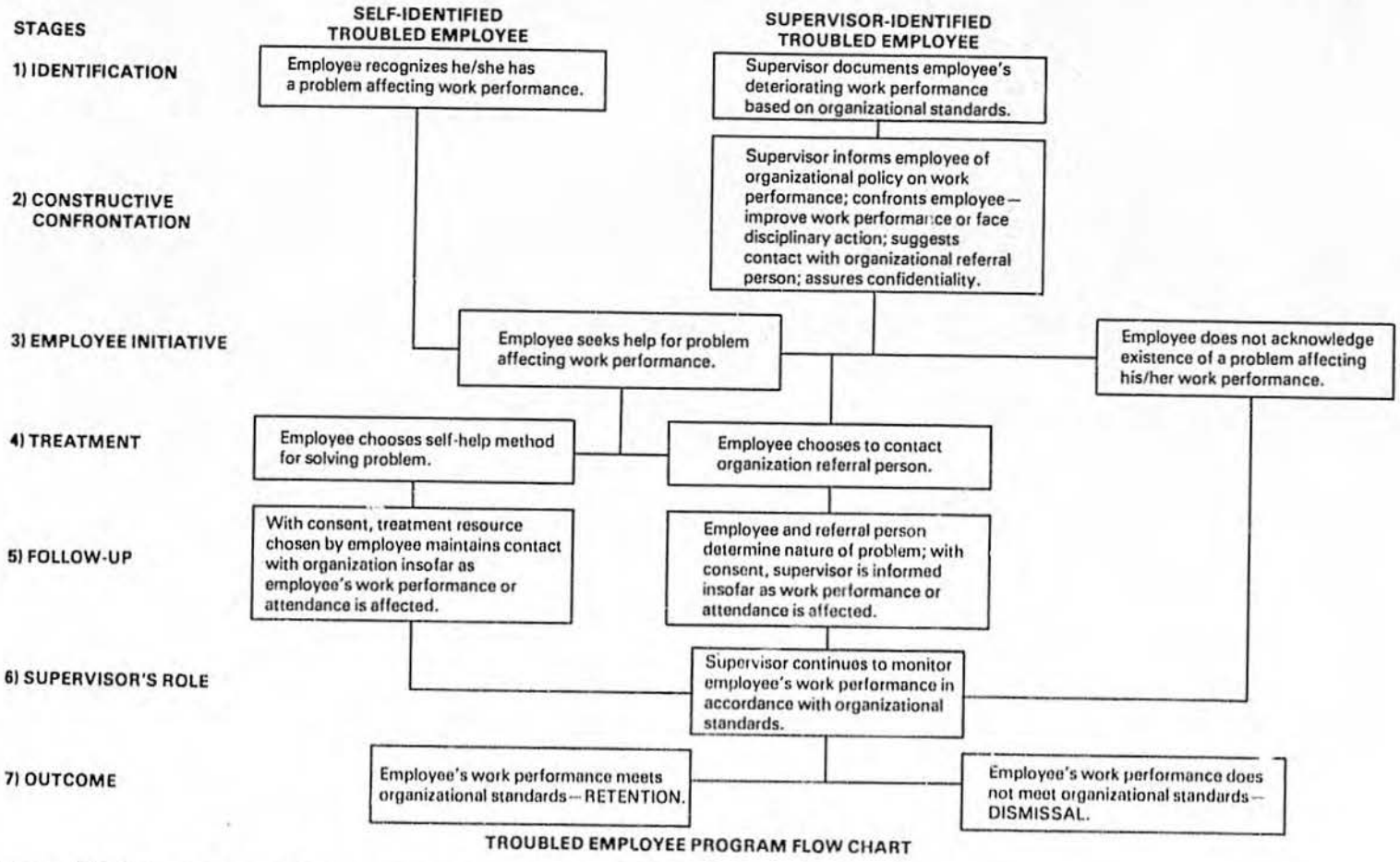
The thrust of Employee Assistance Programs is a common one. A possible alternative to job termination is afforded the individual whose work performance shows signs of deterioration. The employee is encouraged to recognize that his/her poor work performance may be caused by the use of alcohol or the illness of alcoholism. Treatment designed to eliminate the cause of the unsatisfactory work performance is offered. Job performance is the sole criterion for referral to a treatment source. If treatment is not accepted, the employee can anticipate disciplinary action. (See Appendices for further description and resource materials.) Chart I presents the options and opportunities available to the troubled employee.

### Steps Toward Development

By and large, all Employee Assistance Programs (EAP) follow a similar course of development.

- The mayor commits himself/herself to establishment of an EAP.
- A task force/advisory body is created.
- A city policy statement is drafted.
- A policy statement/resolution is issued.
- An Employee Assistance Program is established.

## CHART I.




TROUBLED EMPLOYEE PROGRAM FLOW CHART

[Source: USCM Publication, *Employee Assistance Programs: Toward A More Productive Work Force*]

Particulars of creating an Employee Assistance Program are, of course, less simple. Suggestions by mayors and other local officials are not always met with unanimous sympathy or approval. Often, a justification for the need, value, and proper role of an EAP must be submitted. Fears that the EAP is a threat, that it will produce watch-dog-like behavior, are frequent obstacles. Other objections may relate to financing, threat of public exposure, etc.

Once the concept of an Employee Assistance Program has been approved, the need for mayoral support continues. Questions multiply. Should the program be broadbrush—dealing with all *troubled employees'* problems—or should it deal with alcohol only? Where should it be located—in the personnel department, in the health department, at a more neutral place such as the local alcoholism council? What services should it offer—screening, counselling, referral, treatment? All of these, or some? How can confidentiality be ensured?

### Target City Experience

As of this writing, Employee Assistance Programs in target cities are in various stages of maturation. St. Louis has in place a complete, multi-component, broad-brush EAP. City supervisors and employees are familiar with its purpose and purview. The program is viewed as a resource, not a threat. Its users—both those who refer and those who are referred—realize that the EAP offers assistance. They realize, too, that the program is not a panacea. Mere participation will not guarantee an employee's retention. Participation must be coupled with improvement in job performance.

Albuquerque's Employee Assistance Program was established more recently and still is expanding. A coordinator has been hired, the program has opened formally, and the first employees are being routed through counseling and into treatment. Atlanta's Employee Assistance Program is also new and growing, and handled as an additional activity by employees of the City Personnel Bureau who are backed up by the state which is providing training for supervisors at no cost.

## UNITED STATES CONFERENCE OF MAYORS EMPLOYEE ASSISTANCE PROGRAM

Encouraged by the success of Employee Assistance Programs in Alcohol Abuse Project target cities and cognizant of the value of Employee Assistance Programs, USCM in combination with the National League of Cities (NLC), initiated a broad-brush Employee Assistance Program for the staff of the two organizations.

Though modeled after target city Employee Assistance Programs, the USCM program was somewhat unique. Its purpose was like that of other EAPs. However, its structure, organization, and *appeal* were not. The small number of staff and the limited resources did not permit creation of a self-contained program. Therefore, the concept of a Washington-based public

interest group consortium was devised. By combining populations of similar organizations, USCM endeavored to demonstrate the practicality of implementing an inter-organizational EAP.

Preliminary analysis of the USCM Employee Assistance Program is telling. First and foremost, the program has shown that a consortium EAP is needed and workable. Phasing-in of the EAP has shown also that even diligent adherence to an established work program is not without pitfalls. A program coordinator cannot always anticipate the succession of events. Improvisation is part and parcel of administration. (See Appendix C for further description of the USCM Employee Assistance Program.)

## THE PUBLIC INEBRIATE

The public inebriate (PI) problem is often the most visible of alcohol-related difficulties. At the same time, it is often the most difficult to remedy. State laws regarding PIs vary significantly, thus affecting legal options and consequent program possibilities. Traditionally, most PI programs simply consisted of a revolving door of arrest, overnight incarceration, and release. In light of the growing trend toward decriminalization of PIs by states, it is probable that local courts will be forced to pay more attention to the PI and more enlighted programs will ensue.

Perhaps more than any other lead program, that of the PI is likely to produce frustrations. In many ways, this is a unique population. Often the PI is isolated from the mainstream—from family, friends, and society at large. Often he/she is unwilling or unable to bring himself/herself into treatment and lacks a sufficient support base to provide the needed motivation.

Though relatively innocuous, the PI raises the ire of the downtown merchant and passerby. Local officials are inclined to act upon these groups' demands for appropriate action. Yet, ready solutions are hard to define. While the PI is an admitted eyesore, taxpayers are reluctant understandably to authorize allocation of funds for what amounts to short-term room and board.

In states which have decriminalized PIs, there is greater challenge in dealing with the public inebriate. If the PI is not inclined to present himself for treatment, the local official does not have the option of arrest. Occasionally, this results in arrest in other alcohol-related charges, such as vagrancy, drunk and disorderly, and drinking from an open container.

Certain states have decriminalizing statutes which mandate that a person who agrees to accept alcohol abuse services be provided transportation from the point of pick-up to the appropriate service facility. A requirement of this sort imposes upon a city the need to offer a transportation system—which rarely exists.

Questions and issues of this sort are largely unresolved. We can anticipate the formulation of innovative approaches as increasingly more attention is paid to the problem. Significant inroads into the public inebriate problem have been made through pilot projects geared to redistributing available monies and services. Two of the more successful examples are in operation in San Francisco and Oklahoma City.

## The San Francisco Public Inebriate Program

San Francisco's Public Inebriate Program has impacted in several areas. It has contributed to:

- reduced numbers of public drunkeness arrests and provision of alternative, relevant services by diversion from the criminal justice system;
- reduced numbers of public inebriates desiring services in local hospital emergency departments;
- reduction in the size of the actively drinking public inebriate population;
- provision of a high volume of quality services in a cost-effective manner.

In keeping with the lead program concept, San Francisco's public inebriate program is a multi-faceted, coordinated system which provides needed services at appropriate junctures in the system. A noteworthy aspect of the program is the transportation mechanism which it offers. San Francisco's Bureau of Alcoholism instituted a Mobile Assistance Patrol. MAP provides 24-hour, seven-days-a-week, mobile assistance for any intoxicated individual willing to enter a detoxification facility. During a recent one-year period, transportation was provided for over 7,900 individuals and response was made to over 10,900 calls for service.

Funding for MAP is worth noting. Cooperative arrangements were made with the Office of Criminal Justice, which made it possible to utilize Law Enforcement Assistance Administration (LEAA) monies for provision of the city Mobile Assistance Patrol.

A parenthetical and intriguing hypothesis emerged from San Francisco's PI activities. It was proposed that the PI could be looked upon as an example of, rather than a cause for, the phenomenon of urban decay. By reversing the order of things, one might view the PI as a symptom of a slowly debilitating process. Might it not be the case that the PI was either instinctively drawn or societally pressured to locate in areas of deterioration, not vice versa?

Such thoughts, of course, have implications much broader than the scope of the PI problem. Similarly, the solution is, or might be, one which demands an equally extensive breadth of design.

## The Oklahoma City Public Inebriate Alternative Program

The Oklahoma City Public Inebriate Alternative (PIA) Program is a service developed to reduce the time and money required by the criminal justice system for dealing with the public inebriate. The program provides a temporary, short-term residence for persons who are referred by police and who desire detoxification.

The facility has a 39 person capacity and may house the public inebriate from a minimum of eight hours to a maximum of 24 hours. Actual detoxifica-

tion and later half-way house services are made available through referral arrangements which exist with hospitals and other appropriate resources. Routine and emergency medical backup are available at a nearby hospital.

Total operating expenses amount to approximately $50,600 annually. The city contributes $38,000 in CETA funds for salaries of six full-time staff. In addition, PIA receives financial and in-kind support from three non-profit organizations.

PIA services are without charge. However, the program does not assume the costs of services provided through referral arrangements; these expenses are the responsibility of the PIA client.

Training for PIA staff and volunteers is obtained from two sources. The City/County Health Department offers general technical assistance and training regarding the health needs of the public inebriate. Training which focuses upon the criminal justice considerations of the PI system is provided by the Police Department.

PIA has experienced growing numbers of Police Department referrals. In one month alone—January, 1976—a total of 1,504 referral-admissions were received.

That figure represents a saving to the Police Department of nearly 3,270 hours. Whereas the average client processing time with PIA is five minutes, the average per client processing time in the traditional criminal justice system is almost an hour—26 minutes for jail processing and 30 minutes for court processing.

## PUBLIC INFORMATION/PUBLIC EDUCATION

The extent to which a community is involved with an issue is evidenced readily by activities directed toward publicizing that effort. Key means to this include promotion of the concept, transmission of information, dissemination of materials, and creation of a *public interest campaign.* All of these activities are, of course, within the framework of Public Information. Despite the fact that this lead program was not the sole element of any target city's work plan, it constituted a sizable portion of all cities' tasks. Just as useful services may be of no or little use if they are not known, so too appropriate targets for services are not approachable if they are not identified or made aware of their need for services.

Cities often were reticent to select the Public Education/Public Information lead program because of the many uncertainties inherent in it. It had not been tried and proven; therefore, effectiveness was questionable. Too, this lead program was not quantifiable—making difficult the formulation of definite plans, desired results, and means of implementation.

For most target cities, the local alcoholism council provided the best conduit for public education/public inebriate functions. This body not only had access to the community, it had *a finger on its pulse.* The council was in a position to sense the community's needs and possible reactions to media campaigns. The alcoholism council was valuable further as it let people know that theirs was not an isolated problem; theirs was a problem shared by countless others.

## COORDINATION

Inasmuch as the lead program concept is premised upon encouraging coordination among various elements, to a greater or lesser extent all target cities worked within a framework of coordination. As such, it produced a structure for the more narrow focus of the EAP or the PI program.

For some target cities, the Coordination lead program was a first priority. In Newark, N.J., a workplan was formulated which placed coordination as the first step in lead program development. The decision to deal with the Coordination issue was predicated upon Newark's limited funding and resources. Unlike certain other target cities, Newark joined the Alcohol Abuse Project having had no prior formal programs in the field of alcohol abuse. Whereas other cities approached Coordination from the perspective of facilitating smoother operation and communication among existing services, Newark's program was intended to create and set in place a Coordinating mechanism of services.

Newark Mayor Kenneth A. Gibson, President of USCM, authorized the initiation of a coordinative program. Based upon the USCM model of a joint health, manpower, and criminal justice linkage, respective Newark planners met and agreed to hire an individual to direct the city's alcohol services Coordination program. Assisted by USCM, the coordinator designed a planning grant for submission to the single state alcohol authority. After receiving the agency's approval, city planners then were able to lay the groundwork for appointment of an advisory planning committee.

The first step in preparation for the committee's establishment consisted of development of a flow chart of project activities (see Chart II).

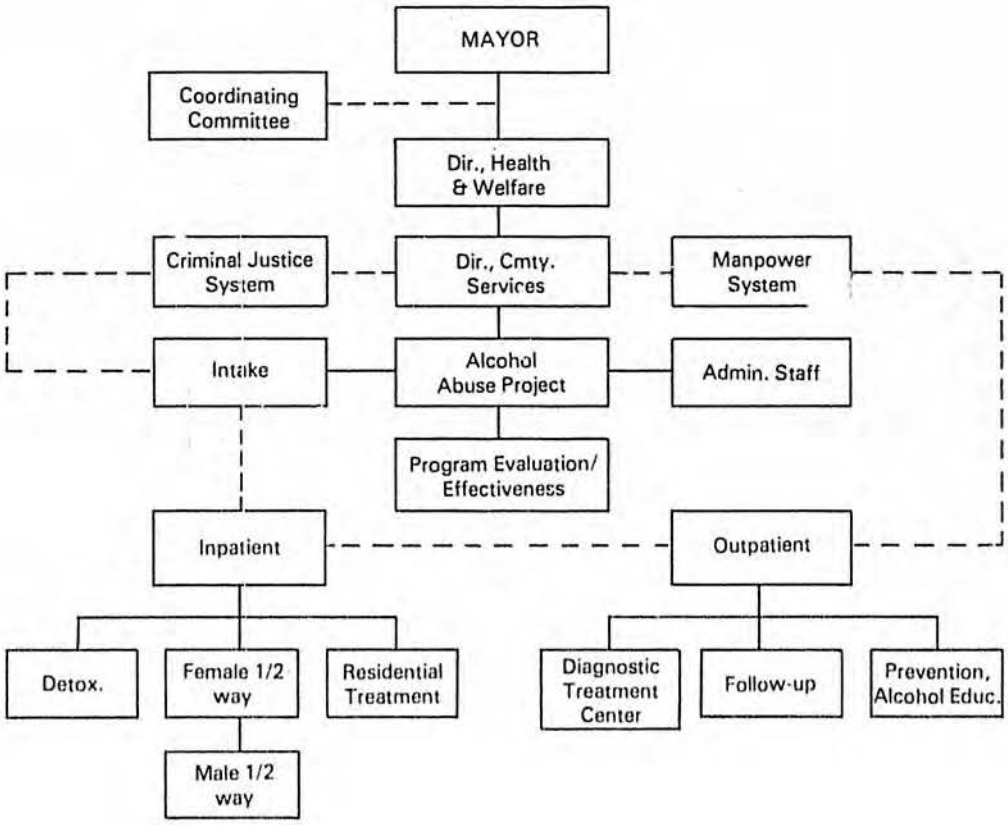
## DRIVING WHILE INTOXICATED (DWI)— ALCOHOL SAFETY ACTION PROGRAMS (ASAP)

Beginning in 1971, the National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation (DOT) provided substantial, multi-year funding for the design of programs which would improve identification procedures, court processing mechanisms, and diversion to treatment for drunk drivers. While DWI programs were not identified as lead programs *per se,* several cities, motivated by the tremendous toll that drunken drivers exact in highway deaths and injuries, expressed interest in DWI program models.

For example, Saint Louis is planning to initiate an Alcohol Related Traffic Offenders Program (ARTOP) which will differentiate between indiscreet social drinkers and chronic drinking drivers. The course of diversion to treatment would be substantially different for these two categories of drunk drivers. As part of development of its comprehensive alcohol abuse services network, Fresno planners are attempting to expand the existing DWI program which operates out of a private, nonprofit hospital.

One requirement of the Alcohol Safety Action Project (ASAP) funding model provided that at least 10 percent of the funds be used to develop program manuals and evaluation criteria. Those publications are available from

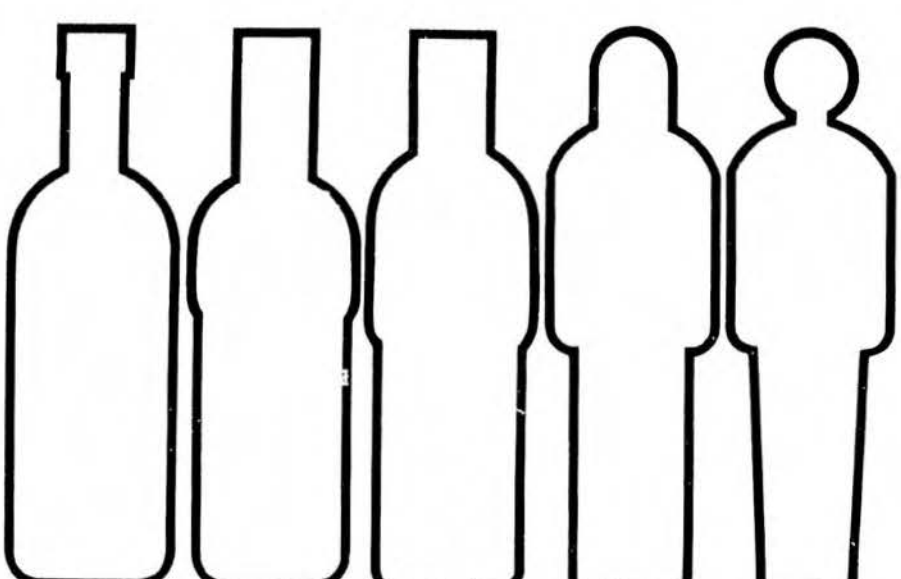
**CHART II**




NHTSA. In addition, a detailed description of ASAP program models is included in the USCM publication, *Alcohol Abuse Programs in Cities: Strategies for Mayors.*

DWI-ASAP programs are particularly attractive in that they can be designed to be virtually self-supporting. Even if the traffic charge is dismissed because the offender accepts diversion to treatment, a condition of the dismissal can be that the offender pay court and treatment costs. As compared with the possibility of losing his/her driver's license, the offender generally is not going to complain about the required payments for these services.

# CHAPTER III: TARGET CITY NARRATIVES



# *San Francisco*

*Mayor Moscone*


## SUMMARY

Mayor George R. Moscone encouraged the city and county of San Francisco to develop a comprehensive alcohol abuse services network. Created to meet community needs, the system provides programs tailored to address specific problems and/or target groups. The scope of services ranges from general education about alcohol and its abuse to medical detoxification, from 24-hour telephone referral to residential treatment. As a whole, San Francisco alcohol services include each of the lead program concepts.


## THE PROBLEM

San Francisco has a greater proportion of problem drinkers than any other city in the state of California. The state, in turn, has higher alcohol abuse statistics than any other state in the country. These facts, in combination with the size of the city and its concomitant diverse resident population, create a need for vast numbers and types of alcohol-related services. Working through the Bureau of Alcoholism, Mayor Moscone has provided constant leadership and encouragement toward solution of the widespread alcohol problem.

## THE SOLUTION

### Employee Assistance Program

As a result of mayoral support, it has been possible to offer many traditional and non-traditional alcohol abuse programs. For example, the Bureau of Alcoholism has introduced an Employee Referral Program. Based upon the broad-brush Employee Assistance Program concept, the program offers assistance to municipal employees whose decreasing productivity evidences alcohol-related and other problems. Still in developmental stages, the EAP has formulated a written policy statement, designed a referral system, provided supervisory training, assisted in client referral follow-up, and disseminated information.

The Employee Assistance Program concept is, to a large extent, the basis for the liaison formed between the city of San Francisco and a National Council on Alcoholism project which aims to introduce EAPs into the private industrial community. Channels for exchange of ideas and information have been established. As a result, a mutually beneficial arrangement exists. Coordination of these groups is evidence of Mayor Moscone's commitment to both municipal employees and private wage earners.

### Mobile Assistance Patrol

Several innovative programs have been introduced in San Francisco. The city operates a Mobile Assistance Patrol (MAP) which provides transportation services to the public inebriate. The structure of MAP calls for Public Inebriate pick-up and delivery to the appropriate intake facility. The MAP van is staffed by two counselor-drivers who are familiar with the treatment needs of the public inebriate and available services. Originally created as a limited pilot program, MAP has met with such success that plans call for expansion of the program to cover the entire city.

### Alcohol Advisory Committee

City-wide services coordination has been encouraged by mayoral staff and department heads. A forum allows for communication between public and private concerns. Important contributions to services planning is derived from the open meetings of the City-Wide Alcoholism Advisory Committee and its numerous task forces. Members of the community are encouraged to participate in task force activities. The committee is charged with certification and review of the county alcoholism plan. Its program committee meets monthly to study service proposals to ensure that county plans and priorities are met.

### Evaluation

Adjustments to the services delivery system have been necessitated by changes in budgeting, administration, and patterns of alcohol abuse in San Francisco. Although the city's first residential treatment centers were designed according to the medical model, the state's imposition of a *per diem* ceiling per client prohibited continuation of this policy. There followed a shift to the less costly social model of treatment. That model requires fewer professional and support staff.

## IMPACT

Evaluation of programs has resulted in identification of specific program requirements and implementation of a still more sensitive evaluation mechanism. Review of the adequacy of service delivery to the public inebriate has revealed a gap in available services. While sufficient detoxification and long-term rehabilitative services exist, there are not enough short-term post-detoxification services. As a result, great numbers of public inebriates go through a *revolving door* syndrome. To discourage this pattern, the Bureau of Alcoholism currently is attempting to add a social model post-detox array of services. As envisaged, such a system would provide a facility with ancillary counseling services for the individual who has completed detox, but requires additional supportive services prior to entering a long-term treatment program.

To further enhance evaluation capabilities, plans have been drawn for establishment of a Management Information System. The computerized system is to supply routine data for studies to be undertaken by the Bureau of

Alcoholism and providers of treatment services. On a monthly basis, information concerning service utilization, demographic characteristics, and types of services are to be made available to facilitate more in-depth research and analysis.

## PROGNOSIS

- Bolstered by mayoral concern, San Francisco will continue to impact upon alcohol-related problems through a comprehensive continuum of services. Although the current system is highly effective, city officials continually are developing ways to improve it.
- It is likely that the Mobile Assistance Patrol will be expanded and, thereby, will bring greater numbers of individuals into treatment. Therefore, there will be a more immediate need for post-detox services.
- Data produced by the Management Information System may identify and support additional programmatic needs.

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# *Albuquerque*

*Mayor Kinney*


**SUMMARY**

Spurred by Mayor Harry Kinney's personal interest and strong support, the city of Albuquerque has effected a coordinated and far-reaching alcohol abuse services system. Brought together through mayoral initiative, a diverse mix of private and public, local and state interests have been mobilized to develop additional services and refine those already in place.


## THE PROBLEM

The city of Albuquerque, not unlike other urban centers, faced the need to respond to the growing problem of alcohol abuse. Although certain services mechanisms were in place, some were not geared to deal with the particular problems in evidence. Further, the coordination necessary to maximize the available services was not sufficient. The appropriate objective, therefore, was to create a services continuum by services revision, addition, and coordination.

## THE SOLUTION

The solution to Albuquerque's alcohol abuse problems was two-fold. First, to ensure optimal use of established services, coordination was encouraged at all levels of service delivery. Second, in response to the needs of the municipal government, an Employee Assistance Program was designed.

### Coordination

Largely as a result of Mayor Kinney's direction, a number of programs and services have been linked in Albuquerque. A focal point for local alcohol abuse services is the General Addictions Treatment Effort (GATE). Staff and resources are available to provide a full range of supportive services needed by the person suffering alcohol-related problems. Services include those for the in-patient and out-patient, medical detoxification, and counseling. Accommodations in approach are made for special populations: women; youth; families of alcoholics; and Native Americans.

Closely tied to GATE are Albuquerque's other alcohol services. The Alcoholism Council is one; it enhances GATE's efforts by providing interested groups and individuals with information, referral, and guest speakers. Additional programs, such as a DWI school, an intermediate care facility, and a Veterans Administration Hospital, round out the city's array of services.

Because alcohol abuse has become so prevalent among the young, and because this population often is found to mix the abuses and/or addictions of alcohol and drugs, effective ties have been established between so-called alcohol and drug communities. By viewing substance abuse as an entity—rather than regarding alcohol and drug abuse as two distinct and separate patterns—Albuquerque has been able to offer services which meet the needs of the combined substance abuser.

A working relationship exists between Albuquerque's alcohol abuse programs and program efforts emanating from the state of New Mexico Division of Alcoholism. The exchange of ideas between Albuquerque and the Division of Alcoholism has fostered a compatible flow of communications, policy formulation, and program design. As a result, alcohol abuse programs such as GATE can be supported by federal, state, county, and city governmental units. And, an efficacious dialogue relating to program priorities, scope of services, and needs can occur among the different groups.

### Employee Assistance Program

When it became evident that an Employee Assistance Program would reduce Albuquerque's administrative costs and, at the same time, provide needed services to municipal employees, Mayor Kinney guided the concept's development through the City Council and followed the program's growth to the implementation stage. Albuquerque's efforts, complemented by support from the State Division of Alcoholism, have produced a new and growing EAP.

## IMPACT

The success of Albuquerque's coordinative efforts coupled with the creation of an Employee Assistance Program have produced significant interest and commitment in the city. The outgrowth of the community's involvement is an awareness of new areas of need. As established alcohol abuse programs require less mayoral and community attention, attention is now focusing on new areas. For example, further study of Albuquerque's Public Inebriate problem is beginning to occur.

## PROGNOSIS

- The Employee Assistance Program will expand in size by virtue of the increasing numbers of employees who utilize its resources.
- Local alcohol abuse program efforts will begin to address the implications of Albuquerque's Public Inebriate population.
- City and state cooperation will continue, with possible concentration upon resolution of the Public Inebriate problem.

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# *Newark*

*Mayor Gibson*


## SUMMARY

Starting with a virtually nonexistent alcohol abuse service structure in the city of Newark, and with very little money to invest in alcohol programs, Mayor Kenneth A. Gibson directed city planners to design a program model which would create incentives toward the development of alcohol abuse services. In recognizing the problems that the misuse of alcohol was causing in Newark, the Mayor set initial program efforts in motion; those efforts now are leading to the development of service components to address those problems.


## THE PROBLEM

Newark was confronted with a number of problems, not the least of which was the paucity of existing governmental or private alcohol services available in the city. Newark did not have a good information base on those few programs that did exist. In addition, the immediacy of other issues prevented the city from making alcohol services a high priority in the allocation of its limited funds. Newark also was facing the prospect of providing services pursuant to the state-mandated decriminalization of public inebriation. Again, the city had few resources and little money for providing transportation and treatment services to public inebriates.

## THE SOLUTION

Under the guidance of Mayor Gibson, the city applied for, and received, a substantial planning grant from the State Alcohol Agency. In view of the Mayor's recognition that the limited funds which were available should be used to create incentives for the development of programs, the state allocation was used to retain a full-time Alcohol Coordinator who was assigned to the Newark Department of Health and Welfare.

The Mayor requested that the coordinator, in conjunction with other city planners, develop a model for a total system. As planned, the system would include service components for city employees and would provide both in-patient and out-patient services. It was hoped that once the comprehensive model was identified, it would be possible to seek support for development of each of the components.

In effect, the city's commitment to begin program development pursuant to a comprehensive, coordinated plan would serve as an incentive to the initiation of efforts in several areas. For example, once out-patient facilities were identified, it would be substantially easier to implement the Employee Counsel-

ing Program. Concomitantly, plans to implement the Employee Counseling Program would serve as an incentive to develop out-patient facilities by identifying a population of potential clients who would use the facilities.

Of equal significance is the fact that the Mayor directed that the coordinated plan fully recognize the advantages that inter-agency involvement could bring to ultimate implementation of the plan. As a result, the Newark Alcoholism and Alcohol Program model was developed. Chart II on page 00 depicts the arrangement of this model.

As indicated on the chart, three major city agencies will be involved in the planning and implementation of various alcohol abuse program efforts. For example, representatives of the Criminal Justice Agency will be involved in the preparations for the transfer of responsibility for public inebriates from the Criminal Justice System to the City Health and Welfare System.

In addition, the City Manpower System will be involved in a number of areas. The Newark Employee Counseling Program will be available to both city supported and Manpower (CETA) supported city personnel. There is also a recognition that Manpower slots could be used to fill treatment and transportation positions in alcohol programs.

## IMPACT

Mayor Gibson's objective of identifying the direction Newark would take in developing its alcohol services structure, as a means to generate such development, has been successful. With the city's Alcoholism and Alcohol Program model in place, efforts have begun to develop and obtain funds for various program components.

The Mayor plans to establish the Mayor's Coordinating Committee to provide continuing guidance to the development of Newark's programs. Once the Committee is in place, the Mayor is prepared to issue a City Administrative Policy and Public Health Statement regarding alcohol abuse and alcoholism. Among other things, this policy statement will announce the establishment of the Newark Employee Counseling Program.

The Director of Personnel for the city of Newark has been attempting, for two years, to develop a counseling program for city employees. Her efforts repeatedly have been frustrated by the absence of any substantial services network in Newark. With the inclusion of the Personnel Department in the planning process for the city's program effort, many of the problems that the Department was facing have been solved, and the plans for the Employee Counseling Program are close to completion.

In the development of the coordination model, a comprehensive survey of existing service agencies was undertaken. With those programs as the basis of the effort, Newark is preparing for the advent of decriminalization. The Welfare Department has indicated its willingness to help support a long-term residential facility which would serve the 4,000 alcoholic clients it has identified. Attempts are under way to find support for remodeling an unused wing of an old hospital to serve as a detoxification facility. Discussions have been initiated with the Newark Housing and Redevelopment Authority regarding the acquisition and rehabilitation of city-owned properties for use as half-way houses.

Finally, the city is attempting to secure training for police officers on their duties and responsibilities under the decriminalization legislation.

As Newark now has a comprehensive, quantifiable plan for the development of its alcohol services network, the State Alcohol Agency has indicated that it may be able to provide the city with additional resources for the development of some of the components identified in that plan.

## PROGNOSIS

- The Mayor's Coordinating Council on Alcohol Abuse and Alcoholism will be impaneled and the city's Administrative and Public Health Policy on Alcohol Abuse will be issued.
- The Newark Employee Counseling Program will be available to provide diagnostic counseling and referral services to city employees.
- On the effective date of the state legislation decriminalizing public inebriation, the city will have initial services in place. Specific efforts to expand the services required by public inebriates will be well under way.
- As each component of the comprehensive program becomes operational, the city, with continued support from the State Alcohol Agency, will be in a position to encourage improvement and expansion of the system.

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# *Saint Paul*

*Mayor Latimer*


## SUMMARY

In 1972, at the initiative of former Mayor Lawrence D. Cohen, Saint Paul planners began designing programs to deal with alcohol abuse and alcoholism within the city. Mayor George Latimer, in June of 1976, reaffirmed the city's commitment to alcohol abuse services in his inaugural address and, again, two weeks later, in the creation of the Mayor's Committee on Alcoholism and Chemical Dependency. The efforts of these two mayors have put Saint Paul in the vanguard of cities in the alcohol services field.


## PROBLEM

As identified by the Mayor and city planners in early 1976, there was a need in Saint Paul for coordination services for existing service components. While Saint Paul already offered Troubled Employee Program services to its employees and had a substantial governmental and voluntary network of alcohol service agencies, there was concern that these services were not being utilized as effectively as possible.

As detailed below, the Mayor's Committee on Alcoholism and Chemical Dependence found that, despite the extensive availability of programs, there were still many unmet needs in the alcohol services area. The Committee found that in Saint Paul:

- Over $20 million per year is being lost to Saint Paul industries in absenteeism, accidents, and other work-related problems resulting from employee alcohol abuse.
- Almost 50 percent of local traffic fatalities involve problem drinkers or alcoholic drivers.
- An estimated 40 to 50 percent of the serious offenders in the criminal justice system have serious drinking problems. Fifty percent of homicides are alcohol related, and 50 percent of convicted rapists had been drinking at the time of the offense.
- More than 80 percent of the incestuous fathers referred to the County Child Abuse Program are alcoholic.
- The Saint Paul Police Department spent $50,000 in 1975 to transport public inebriates to detox centers.

- More than 70 percent of the families referred to the Youth Service Bureau, an alternative to the Juvenile Justice System, have one or more members who are dependent on alcohol or other chemicals.
- Close to 5,000 chemically dependent people live in facilities administered by the local Housing Authority.

It is likely that these statistics, adjusted for population differences, could be found in most cities.

## SOLUTION

Upon taking office in June, 1972, Mayor Cohen, pursuing his personal interest in the human problems caused by alcohol abuse, sought to bring to the city programs which would address those problems. This resulted in the development of one of the first alcohol counseling and treatment programs for municipal employees, the Saint Paul-Ramsey County School District Troubled Employee Program (TEP).

Mayor Cohen also was instrumental in the development of a services network for public inebriates. This network was based at the City/County Hospital. The creation of this network was particularly important as Minnesota was one of the first states to decriminalize public inebriation. Thus, the difficult problems of providing transportation and treatment services to public inebriates fell on Minnesota cities prior to the development of program models for treatment as an alternative to incarceration.

Given these service components, Saint Paul had a substantial services network. In light of the problems created by the lack of coordination, particularly the difficulties of using the existing services network to address the city's unmet needs, the decision was made to create a Mayor's Advisory Committee to review the situation and to make recommendations for improving the coordination and utilization of Saint Paul's alcohol abuse activities.

Mayor Cohen provided the initial impetus to and support of the efforts of city planners in the creation of the committee. Through the change in administration, in June of 1976, Mayor Latimer, as indicated above, took an immediate and active interest in the solution of the problem by naming an Ad Hoc Committee on Alcoholism and Chemical Dependency. The Saint Paul City Council furthered this effort, adopting a Resolution in support of the Committee. In line with the needs which the Committee was to address, Committee members were drawn from representatives of labor, local voluntary alcohol agencies, and local corporations, and included representatives from school district, county, and city agencies.

Upon completion of the review of the coordination problems Saint Paul alcohol service agencies were having, the Committee members made two recommendations:

- That the city establish *a central information/referral agency to communicate to the general public just what facilities and services are available to help the chemically dependent person and family in the Ramsey County area.* This agency would be called the Saint Paul Crisis Center.

- That, to save funds and to build as much as possible on the existing service base, the Crisis Center be developed by expanding the Troubled Employee Program to provide county-wide information and referral services, making the TEP *a highly visible humanitarian arm* of the city.

## IMPACT

Mayor Latimer has received and adopted the recommendations of the Committee and the City Council has adopted a Resolution in support of the city's efforts to fund the Saint Paul Crisis Center from state Alcohol and Drug Formula funds.

The creation of the Committee, its efforts, and its recommendations provide a perfect example of the maturation of a comprehensive alcohol services delivery system. The Crisis Center will serve as a mechanism for coordinating existing service components. This umbrella agency will complement those services by improving client access to each of them.

In completing their review of the current situation in Saint Paul, the Ad Hoc Committee members reported that they *feel so strongly about our report that we stand ready to re-convene or assist the Mayor and Council in the implementation of these recommendations.* In addition, the Committee stressed that it sees the Saint Paul Crisis Center as only a springboard for coordinating public and private agencies in Saint Paul, and that the Center will serve as a forum for addressing Saint Paul's unmet needs in the alcohol abuse services area.

## PROGNOSIS

- By virtue of the commitment of Mayor Latimer and the City Council, the Saint Paul Crisis Center, in all probability, will be staffed and plans made for expansion of its initial responsibilities.
- The litany of statistics cited by the Committee, by focusing on the impacts of alcohol abuse, will serve to promote the development of new service ideas and components.

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# *Oklahoma City*

*Mayor Latting*


## SUMMARY

With guidance and support from Mayor Patience S. Latting, Oklahoma City has made progress in the coordination of its existing array of alcohol abuse services. Linkages between alcohol services and manpower, criminal justice, and health systems have provided a foundation for a comprehensive and well-integrated framework for service delivery.


## THE PROBLEM

An assessment by city officials of community need indicated that alcohol services would be improved by developing further coordination and integration of service delivery within the manpower, criminal justice, and health systems.

## THE SOLUTION

USCM Alcohol Abuse staff discussions with Mayor Latting and other key city officials focused on the need for, and development of, a coordinating mechanism. Support for such a mechanism has been expressed by city officials and appropriate planning participants have been identified.

## COORDINATION ELEMENTS

### The Manpower System

The Oklahoma City Human Resources Department has the capability to identify and refer alcohol abusers. An intake and assessment center has been developed and incorporated into the Comprehensive Employment and Training Act (CETA) service-delivery system. CETA counselors have been trained to identify people who might have alcohol problems. Public Service Employment (PSE) slots, discussed in Titles II and VI of the Act, have been allocated for community service officer patrols to pick up public inebriates. A PSE slot has been allocated also to a newly created detoxification center.

### The Health System

There are three ways in which the health system, by way of the City/County Health Department, interfaces with the alcohol problems of Oklahoma City residents:

1) Public health nurses confront alcohol problems in their relationships with families through *well-baby* and other programs.

2) The City/County Health Department has jurisdiction over four child guidance centers which are oriented toward prevention. These centers work with schools to identify children who themselves might have alcohol-related problems, or who come from a family whose members have such problems.

3) The City/County Health Department offers general technical assistance and training to the staff of the Public Inebriate Alternative (PIA) program. In addition, routine and emergency medical backup is available at a nearby hospital.

### Criminal Justice System

The most direct linkage between criminal justice and alcohol issues occurs in the PIA program. As noted in Chapter II, PIA is directed toward service delivery for, and simplification of, the public inebriate's flow through the criminal justice system. Reduction in client processing time is one indication of positive PIA impact on the criminal justice system.

Another alcohol/criminal justice linkage has occurred in the Alcohol Safety Action Program (ASAP), a federally-funded effort of the National Highway Traffic Safety Administration of DOT. Oklahoma City's ASAP effort was one of 35 demonstration programs implemented in states, counties, and cities for the purpose of proving that a systematic, step-by-step approach could effectively address the increasing DWI problem. A major focus of the ASAPs has been the encouragement of pre-sentence investigation procedures designed to distinguish the *social drinker* who had *one too many* from the person who repeatedly drives while intoxicated. The problem drinker may be ordered by the court to enter a carefully designed counseling and rehabilitation program.

Oklahoma City's ASAP relates not only to the courts, but also to the Community Action Program (CAP), a federally-funded program focusing on rehabilitation and counseling. Forty percent of CAP clients come from ASAP. Through CAP, the ASAP clients may utilize an extensive rehabilitation program which includes day-care and other comprehensive family-child services.

## IMPACT

The opportunity exists for the refinement of a coordinating mechanism which could result in more effective utilization of alcohol services and continued integration of such services within manpower, criminal justice, and health systems. Such integration has added another dimension to the Oklahoma City Council on Alcoholism. Complemented by city agencies and officials, the Council will function as the major coordinating agent of city alcohol abuse services.

City involvement in alcohol abuse program efforts has stimulated public interest in this area. For example, the Kerr Foundation, a private, non-profit organization whose main purpose is to provide financial support to statewide health, education, and cultural programs, has announced plans to convene a

statewide task force on alcohol programs. Areas to be examined include: available services versus local needs; content of education and prevention programs; adequacy of facilities; and funding from private and public sources. Upon completion of its study, the task force will prepare a detailed report of findings.

## PROGNOSIS

- By virtue of Mayor Latting's participation on the Mayor's Advisory Committee on Alcohol Abuse, alcohol abuse issues will continue to receive serious consideration in Oklahoma City.
- Oklahoma City will maintain its support of, and commitment to, alcohol abuse program efforts through the allocation of city monies to such services as the PIA and ASAP.
- The coordination of alcohol abuse services with manpower, criminal justice, and health systems will be strengthened.

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# *Atlanta*

*Mayor Jackson*


**SUMMARY**

The pilot Employee Assistance Program, authorized by Mayor Maynard Jackson in July, 1976, has led to many requests for assistance from departments outside the pilot effort. Seeing a critical need for such services, the Mayor has directed the Personnel Bureau to work with the union to develop procedures which would allow the program to be extended to serve all city employees.


## THE PROBLEM

The director of the Personnel Bureau recognized that alcohol abuse was a significant factor in cases of decreased work productivity. This became evident in listening to employee appeals to the Civil Service Board concerning disciplinary actions. However, the Personnel Bureau did not have a systematic means to help city employees with drinking or other personal problems.

## THE SOLUTION

Mayor Jackson authorized the Director of Personnel to start a pilot Employee Assistance Program in the Vehicle Maintenance Division as a means to determine the need for such services, as well as the feasibility of providing them. Since no additional funds were available for support of this effort, existing Personnel Bureau staff has been used. The EAP Coordinator also coordinates the Exit Interview Program. Two motivational counselors have been assigned to the EAP, and the typist for the Exit Interview Program also works for the EAP. The state of Georgia has provided free technical assistance for staff training which includes learning techniques in referral and recognition of continuous job performance problems. Thus, the EAP pilot effort was started with just $25.00 which was used to print the flyer announcing the EAP to the employees in the Vehicle Maintenance Division. However, other departments became aware of the EAP and referred employees with special problems to the Personnel Bureau. It was decided to allow these critical cases to take advantage of the pilot EAP services.

Employees may be referred to the program by a supervisor or union steward or may come voluntarily. The employee makes an appointment with one of the motivational counselors, and the counselor helps the employee determine the nature of his or her problem. If the problem cannot be identified easily, the employee is referred to a person in the state's vocational rehabilita-

tion division who has agreed to provide professional diagnostic back-up without charge. After a preliminary determination of the problem is made, the employee is referred to the appropriate community agency. The role of the Personnel Bureau is to assess the probable cause of an employee's work performance problems, to motivate the employee to accept treatment, and to refer him or her to the appropriate community resource.

Since health services in Atlanta are a responsibility of county government, the city does not own any alcoholic or psychiatric treatment facilities. However, the county provides several neighborhood mental health centers and an in-patient alcoholism treatment center. There are three private psychiatric hospitals and two private general hospitals with strong alcoholic and psychiatric units in the two counties in which Atlanta is located. There is also a veteran's hospital in the Atlanta area.

Payment for services is the responsibility of the employee. Thus far, employees in the program have chosen to use public facilities because of the lower cost. Fees at the county mental health centers are on a sliding scale system, and presently treatment at the in-patient alcoholism treatment center is free. Although the city's hospitalization plan does not specifically cover alcoholism, the insurance carrier has agreed to treat alcoholism as any other illness. The city's hospitalization policy provides a maximum room benefit of $50 per day and a maximum major medical benefit of $50,000.

The counselors try to keep in close touch with the employees in the program in order to ensure that adequate treatment is administered. An Evaluation of the job performance of supervisory referred employees is conducted after an appropriate period of time—usually three months. Employees who come voluntarily are asked to make a self-evaluation of the assistance received.

## IMPACT

Nineteen clients have been served in the pilot program. Half of the cases have concerned alcoholism. Despite the short period of time that the program has been in operation, results are beginning to be visible. One employee with a drinking problem has returned to work after 30 days of in-patient treatment and is doing well. Three other employees are attending Alcoholics Anonymous meetings regularly and seem to be functioning well on the job. Two employees with emotional problems have improved greatly—one after an in-patient stay of 26 days at a mental health center—according to their supervisors. No one has been terminated, but three persons referred to the EAP have resigned.

## PROGNOSIS

- As indicated, the EAP was started in July, 1976, but extensive research and preparation were done prior to establishing the pilot program. Field visits were made to community agencies in every anticipated problem area—alcohol, drug, marital, financial, legal, psychological. The counselors attended two training courses on alcohol and drug abuse and are continuing to attend a monthly forum of workers in Employee Assist-

ance Programs in the Atlanta area. Thus, it would be relatively easy to convert the pilot effort into a government-wide program to provide services to all city employees. The Personnel Bureau and the union hopefully can develop an approach for a total program in the very near future, at which time the Mayor has indicated that he would sign the executive order to establish such a program.

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# *Fresno*

*Mayor Wills*


**SUMMARY**

Inspired by an enthusiastic and effective Mayor, the Fresno City Council approved development and implementation of an Employee Assistance Program for municipal workers. Results of Fresno's program efforts attest to the viability of the lead program concept.


## THE PROBLEM

It is generally agreed the alcohol abuse among employees places severe constraints upon productivity of an organization. Fresno officials estimated that alcohol-related problems of municipal workers were consistent with national trends and possibly could have been costing the city a minimum of $420,000 per year.

Various agencies of the community had demonstrated concern for the problem of alcoholism and a number had appropriated resources to work on the problem. However, no specific services network had been established for municipal employees. Additionally, linkage with the County Health Department, the major provider of health services to the city and county, had not been explored fully in relation to alcohol abuse services.

## THE SOLUTION

Mayor Ted C. Wills initiated establishment of a broad-brush Employee Assistance Program and obtained support for it from the city administration and the Fresno City Council. The Mayor's major effort and success were in bringing community attention to alcoholism. In doing so, he brought together many of the public, private, and voluntary agencies which heretofore had not met. These efforts already have been beneficial in that a community-wide committee—consisting of funding agencies, providers, law enforcement personnel, and businessmen—has banded together to develop a coordinated treatment program for the public inebriate. City administrative staff has been appointed to the County Alcoholism Advisory Council and is working on a Public Inebriate program as well as the Occupational Alcoholism program.

The municipal Employee Assistance Program, from introduction of the concept to formulation of a program to establishment of a policy statement on alcohol abuse to final implementation of the program, has been a joint effort by

the Mayor-Council and city administrative staff. Following formal City Council approval of the EAP, the administrative office designated an Employee Assistance Program Coordinator located with the City Personnel Department. Among other duties, the Coordinator was responsible for training supervisory staff to recognize employees needing referral to the EAP.

## IMPACT

The primary results of Fresno's alcohol abuse program efforts were design and establishment of a viable Employee Assistance Program. The program testifies to the leadership of Mayor Wills and the cooperative spirit manifested by various segments of the community.

Despite the incontestable success of the Employee Assistance Program, perhaps the most striking result of Fresno's alcohol abuse program efforts is to be seen in the ever-increasing community involvement.

Establishment of an Employee Assistance Program encouraged the cooperation of a number of ancillary services and organizations. Arrangements for supervisory training, referral, and public information were made through the local Fresno Council on Alcoholism, which had been created previously by the city and county through city revenue sharing funds and additional contributions by county and private sources. Increased demands led to increased communication between the Alcoholism Council and the city. As Fresno officials looked to the Alcoholism Council for additional assistance in the provision of services, additional opportunities arose for meetings, discussions, and policy evaluation.

Relations with the county were stimulated similarly. As the city of Fresno maintains no health department, it looks to the county for the provision of health services. Therefore, investigation of health and mental health services for an Employee Assistance Program fostered more frequent communication between Fresno City Hall and the County Health Department. As a result, city/county ties were strengthened appreciably.

When a county substance abuse services handbook detailing referral resources was developed, it was made available for use by city alcoholism program personnel. When the county DWI program director expressed an interest in visiting a model DWI program, Mayor Wills facilitated his attempts to secure funds. As a result, the Fresno DWI program director was able to visit Phoenix, a city which operates an exemplary DWI program.

Mayor Wills solicited participation by many groups outside of government. In addition to members of the County Manpower and Health Departments, the Mayor's advisory group consisted of individuals from the community *at large.* Representatives of the religious, business, and voluntary sectors were given an opportunity to contribute to the development of alcoholism strategies and policy. So broad was the makeup of the advisory group that members of the local wine industry were invited to participate.

A more extensive information base quite naturally gave rise to discussion of broader issues. Working with his advisory group, Mayor Wills explored problems of public inebriation, public information, the youthful alcohol abuser, and the dram shop (bar owner insurance) statutes.

A further effect of initial alcohol abuse program efforts was the generation of interest on the part of Fresno officials to participate in state and national alcoholism activities. Relations were established with involved state and federal legislators. In addition, Mayor Wills introduced alcohol-related policy considerations to the California League of Cities and served on the United States Conference of Mayors Alcohol Abuse Project Advisory Committee.

## PROGNOSIS

- The municipal Employee Assistance Program will aid growing numbers of city personnel. The program's course of development could serve as a model for other cities and/or counties.
- Cooperation between the city and county will continue to expand. It is conceivable that the Employee Assistance Program will be introduced at the county level.
- A joint city/county alcohol abuse program may be devised to concentrate upon the public inebriate.
- Fresno will impact upon state alcohol activities through leadership in the California League of Cities and at the national level through the United States Conference of Mayors.

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# *Toledo*

*Mayor Kessler*


## SUMMARY

Encouraged by Mayor Harry Kessler's support and commitment, the city of Toledo has developed, and is expected to implement, an Employee Assistance Program. Cooperative linkages between city agencies have effected mobilization of resources needed for development of the program.


## THE PROBLEM

Mayor Kessler and other key city officials became concerned about the consequences of alcohol abuse for the city of Toledo. Alcohol problems among city employees and other citizens were on the increase. To address this problem adequately, it was necessary to develop a comprehensive plan to modify the existing service-delivery system.

## THE SOLUTION

In response to alcohol abuse and other family and personal problems among municipal workers, an Employee Assistance Program was developed. Mayor Kessler recommended that a broad-brush program be designed to address alcohol-related and other mental health problems that interfere with work performance.

Under the guidance of the Mayor, various city department heads initiated discussions resulting in the designation of key individuals to begin the actual program planning process. As a consequence, a proposal has been drafted and distributed to all appropriate decision makers.

Officials from the city departments of Personnel, Health, and Human Resources, along with representatives from the Mayor's Advisory Committee on Alcoholism, the Northwest Regional Council on Alcoholism, and local labor unions, have had an opportunity to review and comment on the first draft of the Employee Assistance Program proposal.

The current work program calls for the Mayor to appoint these individuals to a task force which will have full authority to, and responsibility for, implementing the final program. The task force will be an accountable decision-making body which will have the authority to resolve various issues inherent in program implementation.

Viewed as a vehicle for programmatic planning and implementation, the task force will have several notable features. First, it will foster communication among various city agencies. Second, opportunities will exist for input by the state Department of Health through the Northwest Regional Council on Alcoholism. This is likely to enhance the city's efforts to resolve implementation issues, such as funding, supervisory training, and the need for an assessment of community resources. Third, the task force will be issue-specific with a short-time perspective, i.e., its purpose is to resolve specific programmatic issues and thus provide a vehicle for the transition from program planning to implementation. Fourth, the Task Force will be able to demonstrate the utility of inter-agency communication and coordination as a planning mechanism for other city services.

## IMPACT

Although the EAP has not been implemented yet, the planning process has improved the communication flow among city and regional officials, thus improving coordination potential on such matters as budgetary issues, staffing requirements, availability of community resources, and labor-management relations. In addition, the potential for coordination exists for other services, including other city programmatic efforts in the alcohol field.

## PROGNOSIS

- Mayor Kessler's continuing support of the program model will be manifested in the creation of the task force.
- With the support of the task force, the Employee Assistance Program will provide a mechanism for service delivery to city employees.
- Communication flow and coordination between city and regional officials will continue.
- By virtue of the design of the Employee Assistance Program, it will be possible to foster the development of *a continuum of care* alcohol and mental health service-delivery system.

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# *St. Louis*

*Mayor Poelker*


## SUMMARY

Realizing that St. Louis needed to provide help to city employees with drinking and other personal problems, as do many private firms there, Mayor John H. Poelker authorized the Department of Personnel to develop an Employee Assistance Program. He also gave the Municipal Court strong backing to develop an Alcohol-Related Traffic Offenders Program which was to differentiate between the social drinker and the problem drinker.


## THE PROBLEM

### Troubled Employees

St. Louis officials became aware that deterioration of work performance, tardiness, poor attendance, missed work schedules, or other unsatisfactory practices often can be traced to excessive drinking, drug abuse, or other personal problems. Additionally, such poor performance on the part of troubled employees can demoralize productive co-workers.

### Drinking Drivers

In 1975, there were approximately 776 persons arrested in St. Louis for driving while intoxicated (DWI). This number is low for a large metropolitan area, but it is believed that the actual DWI problem is of greater magnitude. However, the city does not have an intoxicated drivers' program which would allow for increased arrests and treatment and rehabilitation of drinking drivers.

## SOLUTION

### Employee Assistance Program

The director of the Department of Personnel and his director for training had applied unsuccessfully for two years for federal funds for an Employee Assistance Program (EAP). Documenting need for the federal government made the Director of Personnel realize how much EAP services were needed in the city of St. Louis, and he approached the Mayor for support of a pilot EAP. Funds were provided from the budget of the Department of Personnel, and the Mayor gave his complete backing to the program and the low-key approach to be taken in publicizing the services.

Two departments were selected for the pilot effort—the Department of Streets and the Department of Public Utilities. An EAP coordinator was hired under contract specifically to develop and direct the pilot program. Much of the success of the program has been credited to the coordinator who has established EAPs for more than 25 private companies in the St. Louis area.

Purposely, no public announcement was made about the program and no executive order was issued. Instead, the Director of Personnel contacted the directors of the two selected departments to explain the nature and purpose of the proposed EAP. Individual department heads needed to be convinced that EAP services would lessen their personnel problems and increase productivity. Without proper explanation, the EAP could appear to represent more work. Then, the department heads were put into direct contact with the EAP coordinator to work out voluntary and supervisory referral procedures, as well as procedures relating to unions within each department.

The coordinator believes that the EAP offices must not be located in the Department of Personnel. In the case of the city of St. Louis, the EAP office is in a building housing some city health department services, which is situated about three miles from the civic center complex which includes the offices of the Department of Personnel.

He also believes that during the first year when an EAP is being developed, the coordinator must literally *walk* the clients through the services to which they are referred. For example, if a client must enter a hospital for treatment, the coordinator should accompany him/her in order to gain familiarity with procedures and personnel and in order to have enough confidence in the effectiveness of the facility to refer future clients unaccompanied.

The coordinator does not believe that EAP staff should provide in-depth counseling, but does believe that EAP staff must talk with a client for a total of about six hours which entails probably five sessions. Most clients need to discuss their situations at length before the exact nature of their problem can be determined and referral to appropriate services made.

### Alcohol-Related Traffic Offenders Program (ARTOP)

Mayor Poelker has authorized the Municipal Court to develop and administer an Alcohol-Related Traffic Offenders Program (ARTOP) which is to augment the efforts of the three-year-old county ARTOP. The proposed city effort will fully utilize education, corrections, and rehabilitation systems to assit the drinking driver. The Probation and Parole Office of the Municipal Court will coordinate the program with the assistance of the Safety Council of St. Louis and the Greater St. Louis Council on Alcoholism.

One of the main features of the proposed ARTOP is the differentiation between the social drinker and the problem drinker who is driving while intoxicated. A social drinker is considered a person who has on occasions consumed intoxicating beverages and who suddenly discovers that the ability to operate his vehicle is impaired due to the amount of alcohol consumed. Such an individual will be helped through education and counseling. However, the problem drinker needs long-term, more in-depth treatment and rehabilitation. Existing St. Louis treatment facilities will be utilized for selected clients.

An important new factor relating to implementation of the proposed ARTOP is a section in a new city ordinance which prohibits any person from operating a motor vehicle when the person has ten one-hundreds of one percent or more by volume of alcohol in the suspected individual's blood. Assignment to ARTOP will occur either before or after sentencing, or during a pre-sentence investigation, at which time the Probation and Parole Coordinator will ascertain the following information:

- blood alcohol content at the time of arrest;
- record check for other alcohol-related offenses;
- completion of a short drinking personal-history form;
- administration of the diagnostic instruments, particularly to determine if the individual is a social or a problem drinker.

The Mortimer-Fillkens Test, developed by the University of Michigan, will be used to differentiate between the two categories of drinking drivers. Based on this information, the appropriate referral will be made to either:

- the drinking driver class with a written notice to be sent to each participant 10 days in advance; or
- treatment, rehabilitation, and follow-up.

The Probation/Parole intake information will be sent to the Council on Alcoholism and/or the Safety Council, both of which will be involved in the education component.

The total budget for the first year program will run about $125,000. The application for these ARTOP funds will be channeled through the Missouri Division of Highway Safety, which supports the proposal, to DOT. However, the program eventually will be self-supporting.

The Police Department recently received a $100,000 grant from DOT to work the overtime necessary to fully process drunken drivers. This police overtime will supplement the proposed ARTOP effort.

## IMPACT

### Employee Assistance Program

The pilot program completed its first year on September 13, 1976, handling 39 cases, 30 city employees, 24 of whom had alcohol problems, and nine family members, eight of whom had alcohol problems. More than half (14) of the employee alcohol abuse cases have shown improvement, as evidenced by some continued sobriety. Only five employees have been terminated.

As a result of the success of the pilot program, the Mayor authorized that EAP services be offered to the remaining department heads, all of whom have expressed a desire to participate. In fact, during the pilot program, some department heads who became aware of the services asked that a few of their employees be helped, and the EAP responded.

The EAP saved the city of St. Louis $38,500 during the pilot year. This figure is derived by using the National Council on Alcoholism formula which holds that the average cost of all alcoholics on any average payroll is an amount equal to 25 percent of the annual compensation. The breakdown on St. Louis during the pilot EAP is as follows:

| | |
|---|---|
| Annual Average Cost of Employee | $ 11,000 |
| Number of Employees Aided | 14 |
| Cost of Total Employees | 154,000 |
| Projected Cost Savings (NCA Formula) | 25% |
| Program Savings | $ 38,500 |

## PROGNOSIS

### Employee Assistance Program

- It is estimated that approximately 25 clients will be served next year, which would result in a savings of $68,000 to the city if funding for the program continues to be available. Perhaps more important than the dollar savings, is the fact that the city is looking at its employees as total people whose problems can be overcome. Certainly, the city will realize a greater, long-range benefit in the form of employee commitment to a supportive organization.

- Additionally, since Public Service Employees can be served by the EAP, it is possible that the city's Manpower Division will be able to collaborate with thePersonnel Department on activities of mutual interest. Such activities could include a needs and resource assessment of services available to alcohol abusers and could result in a city-wide directory of programs and facilities, a possibility under discussion.

### ARTOP

- It is projected that drunken driving arrests will increase substantially under the first year and succeeding years of the proposed ARTOP effort. This concerted effort on the part of the city to combat drunken driving also will serve to heighten the sensitivity and caution of the community in regard to this problem.

## CITY CONTACTS:

**Lewis O. Collins**
**Clerk/Administrator**
**St. Louis City Courts**
**Room 305 Kiel Auditorium**
**1400 Market Street**
**St. Louis, Missouri 63103**
**Telephone: 314/453-4701**

**James R. Cummings**
**Employee Assistance Office**
**Missouri Theatre Building**
**634 North Grand, Room 519**
**St. Louis, Missouri 63103**
**Telephone: 314/533-5950**

# *Bridgeport*

*Mayor Mandanici*


## SUMMARY

Mayor John C. Mandanici has taken significant steps to generate community support for alcohol abuse program efforts in Bridgeport. Heightened community awareness has resulted in greater concern for alcohol abuse problems in general and those of the public inebriate in particular. Creation of a mayor's task force offers a mechanism by which the local business and civic communities might cooperatively discuss the city's alcohol problems and submit recommended courses of action.


## THE PROBLEM

The presence of public inebriates is disturbing to both the downtown merchant and the passerby. The situation in Bridgeport was heightened in July, 1976, with the passage of state legislation removing the option of arrest for public inebriation. Given a mandate to provide an alternative to incarceration of publicly-inebriated individuals, Bridgeport officials were faced with the need to locate and make available potentially suitable services.

Attempts to offer alternate responses to incarceration pointed up a number of complications. Primary difficulties included: the need for additional detoxification facilities and a temporary shelter; the absence of a transportation network; and insufficient coordination between services.

Shortage of funds posed further problems. Due to severe fiscal constraints, Mayor Mandanici was unable to allocate additional city monies for alcoholism activities. Attempts to secure outside funds were problematic as sources frequently failed to recognize Bridgeport's true financial needs. A traditionally middle-class urban area, Bridgeport is surrounded by many of the state's wealthiest cities and towns. As a result, it often is assumed that Bridgeport has far greater resources than, in fact, it does.

## THE SOLUTION

Mayor Mandanici identified resolution of the public inebriate problem as foremost among alcohol abuse program efforts. Although no new funds were available, the Mayor's commitment and leadership tapped a wide variety of already existing services and resources. The coordination of these autonomous units resulted in both a union of efforts and demonstrable change.

First, Mayor Mandanici gave freely of the time and talents of his staff. The entire Human Resources Development Department contributed to program

development, and one of the department's planners was designated coordinator of all of Bridgeport's alcohol activities. In addition, the Mayor encouraged participation by, and input from, the city of Bridgeport Health, Criminal Justice, and Manpower departments.

The voluntary contributions of local academic and professional communities were encouraged as well. When officials recognized the need to determine and coordinate available treatment and rehabilitation services, city planners met with representatives of the Junior League and the University of Bridgeport to solicit their expertise in design of a document to assess services.

City support for the Greater Bridgeport Area Council on Alcoholism continued. Created to serve as a link between the various service providers throughout the city and region, the Council was financed by city, state, and voluntary contributions.

Mayor Mandanici initiated frequent communication with the State Alcohol Council. The exchange of information and ideas served to complement the city's knowledge of statewide activities. Not only did the State Alcohol Council (SAC) apprise the Mayor of on-site assistance available for introduction of training programs and occupational assistance programs, the SAC executive director *loaned* personal staff to further aid Bridgeport planners.

Clearly visible examples attest to Bridgeport's success in dealing with the public inebriate. Mayor Mandanici was instrumental in the designation of 23 detoxification beds at a local state hospital. Opening of the detox facility constituted an impressive kick-off for the city's alcoholism program. Mayoral impact later helped to secure a half-way house in Bridgeport.

A mayor's task force was approved whose members would be drawn from business, voluntary, and government organizations. It was charged with the following responsibilities:

- to examine the problems involved in transporting the public inebriate and to suggest solutions;
- to involve the business community;
- to identify future areas of need.

## IMPACT

The primary goals of Bridgeport's alcoholism program have been realized and, in some cases, surpassed.

The public inebriate problem was addressed and positive steps were taken to provide facilities and relevant professional training.

Equally important, various segments of the community became aware of alcoholism as a multifaceted and pervasive problem. Once made aware, many offered assistance in dealing with the problem. Interested groups and individuals were encouraged to participate jointly in program development design.

The Mayor's alcohol abuse coordinator participated in a day-long seminar on alcoholism and alcohol abuse held at the local mental health center. Attend-

ing the seminar were representatives of many different local services and resources.

Involvement of the medical community and Bridgeport's Medical Society went beyond that projected. Physicians responded enthusiastically to city efforts to publicize the extent of the problem and the need to treat it accordingly. Mayor Mandanici agreed to sponsor a Bridgeport physician's application for attendance at a physician training institute on alcoholism sponsored by the University of Pennsylvania School of Medicine.

Communication with the State Alcohol Council enhanced the Bridgeport planners' appreciation of state programs and trends and afforded access to the experiences of other Connecticut cities. As the public inebriate problem was winding down, recently increased sensitivity to alcoholism made other alcohol-related needs apparent. The same urgency which compelled local officials to deal with the public inebriate problem was extended to new areas of concern. Groundwork was laid for consideration of comprehensive training programs, prevention programs, and an occupational assistance program for municipal employees.

## PROGNOSIS

- Public inebriate program efforts will continue until the transportation difficulty is resolved.
- As the likelihood that future city funds will be available for alcoholism programs is not great, efforts to locate additional funds, especially for women and youth, will be intensified.
- Involvement by the medical community is apt to increase as is the involvement of the industrial sector. Ties between these two groups may be strengthened through cooperative ventures such as the establishment of occupational alcoholism programs in Bridgeport's business community.

## CITY CONTACT:

**Dana Fiorini**
**Planner**
**Department of Human Resources**
**45 Lyon Terrace**
**Bridgeport, Connecticut 06604**
**Telephone: 203/576-7176**

# *AFTERWORD*

Accepting the need to deal with alcoholism and alcohol abuse is the first step towards resolution. Given limited resources and ever-changing local priorities, it is logical to maximize available resources wherever possible, allocating additional funds, manpower, and ancillary support only when necessary.

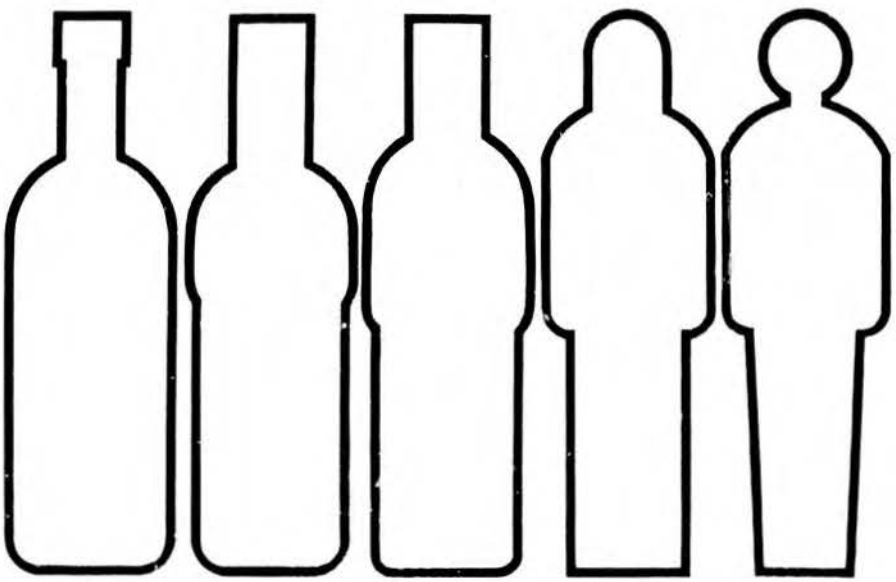
Such thinking formed the basis for the program described in this publication. The United States Conference of Mayors Alcohol Abuse Project has focused upon assisting mayors and other local officials in the development of alternative strategies for approaching alcohol abuse problems.

The preceding pages represent an attempt to review the experience of the U.S. Conference of Mayors Alcohol Abuse Project through an account of the development and administration of pilot projects in cities. A concerted effort has been made to be as forthright and realistic as hindsight will allow. In that spirit, we have included mention of trouble spots, errors in judgment, and other difficulties attributable to chance and human nature. Our design has been to regard these difficulties as instructive, integral parts of demonstration projects, for they have encouraged us to analyze why certain programs, approaches, or concepts failed to materialize as we had hoped.

Equally important have been the successes. In the majority of cases, introduction of pilot projects in target cities has illustrated that programs do work and why. The concert of anticipated and unanticipated results has taught us a lesson. We can now say with some assurance that certain methods are likely to succeed and that others present some risk.

It is hoped that the narrative sections in combination with the final appendices and references will provide guidance to mayors and other local officials in impacting upon alcohol abuse and alcoholism. Based upon our experience, we are confident that, given mayoral leadership and community support, meaningful impact is not only feasible, it is inevitable.

# *APPENDICES*



## *Appendix A*

### CITIES RESPONDING TO USCM ALCOHOL ABUSE SURVEY

ALBUQUERQUE, New Mexico
ALEXANDRIA, Virginia
AKRON, Ohio
ANCHORAGE, Alaska
ATLANTA, Georgia
AUSTIN, Texas

BALTIMORE, Maryland
BATON ROUGE, Louisiana
BIRMINGHAM, Alabama
BOSTON, Massachusetts
BUFFALO, New York
BUTTE, Montana

CASPER, Wyoming
CEDAR RAPIDS, Iowa
CHARLESTON, South Carolina
CHARLESTON, West Virginia
CHARLOTTE, North Carolina
CHATTANOOGA, Tennessee
CHICAGO, Illinois
CINCINNATI, Ohio
CLEVELAND, Ohio
COLORADO SPRINGS, Colorado
COLUMBUS, Ohio

DALLAS, Texas
DAYTON, Ohio
DENVER, Colorado
DES MOINES, Iowa
DETROIT, Michigan
DISTRICT OF COLUMBIA
DULUTH, Minnesota

EL PASO, Texas

FORT WORTH, Texas
FRESNO, California

HONOLULU, Hawaii
HOUSTON, Texas

INDIANAPOLIS, Indiana

JACKSONVILLE, Florida

KANSAS CITY, Missouri

LANSING, Michigan
LEXINGTON, Kentucky
LINCOLN, Nebraska
LITTLE ROCK, Arkansas
LOS ANGELES, California
LOUISVILLE, Kentucky

MADISON, Wisconsin
MANCHESTER, New Hampshire
MEMPHIS, Tennessee
MILWAUKEE, Wisconsin
MINNEAPOLIS, Minnesota
MOBILE, Alabama

NASHVILLE, Tennessee
NEW ORLEANS, Louisiana
NEWARK, New Jersey
NORFOLK, Virginia

OAKLAND, California
OKLAHOMA CITY, Oklahoma

PHOENIX, Arizona
PITTSBURGH, Pennsylvania
PORTLAND, Oregon
PROVIDENCE, Rhode Island

ROCHESTER, New York

SACRAMENTO, California
SAINT LOUIS, Missouri
SAINT PAUL, Minnesota
SALT LAKE CITY, Utah
SAN ANTONIO, Texas
SAN DIEGO, California
SAN FRANCISCO, California
SAN JOSE, California
SAVANNAH, Georgia
SEATTLE, Washington
SPOKANE, Washington
SOUTH BEND, Indiana

TAMPA, Florida
TOLEDO, Ohio
TUCSON, Arizona
TULSA, Oklahoma

WILMINGTON, Delaware

**LEAD PROGRAM: Coordination**

City:
Date:

| ELEMENTS | GOALS & OBJECTIVES | ACTION STEPS/ RESPONSIBILITY | RESOURCES | TIME | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | J | F | M | A | M | J | J | A | S | O | N | D |
| Mayor's Coordinating Committee | Establish forum for developing approaches to alcohol abuse problems in city | Ask Mayor to appoint Coordinating Committee and make recommendations to Mayor | Health, Manpower, Criminal Justice Planners | X— | | | | | | | | | | | |
| Mayor Designates Chairperson | Provide leadership to Coordinating Committee | Provide Mayor with recommendations re: Chairperson | Members of Mayor's Coordinating Committee | | X | | | | | | | | | | |
| Public Policy Statement | Establish City Administrative Policy and Public Health Policy | 1) Mayor policy decision on advice from Coordinating Committee<br>2) Statement issued by Mayor | Mayor's Coordinating Committee | | | | X | | | | | | | | |
| Mission Statement | Plan, develop, implement, and monitor programs and policies to mitigate city alcohol abuse problems in accordance with public policy statement | 1) Preliminary appraisal of local problems<br>2) Preliminary identification of existing programs<br>3) Analysis of social constraints<br>4) Draft preliminary statement for Mayor's approval | Program Coordinator and committee with staff assistance, USCM Alcohol Abuse Project Staff | X— | | | → | | | | | | | | |
| Goal Statement | Develop statement of goals for addressing city alcohol abuse problems | Elements 1-5 to be completed by: (date) | | | | | | X | | | | | | | |
| Local Assessment | Conduct needs analysis; gather and analyze supportive data | Detail composition of needs analysis, e.g., define and identify target population, compile listing of resources, etc. | Coordinating Committee and staff, intergovernmental personnel, USCM Alcohol Abuse Project Staff | X— | | | → | | | | | | | | |

## *Appendix C*

### UNITED STATES CONFERENCE OF MAYORS EMPLOYEE ASSISTANCE PROGRAM

#### Report

After only four months of operation, the Employee Assistance Program for Public Interest Groups had unusual success with a target population that previously was believed to be especially difficult to penetrate. Because this program uses a consortium model and because its target population, the professional employee, is unique, several observations may prove useful to those private and/or governmental organizations which have established or are considering the establishment of employee assistance programs.

#### The Concept

Employee assistance programs traditionally have been directed towards line-staff employees in large industrial or governmental organizations. These programs, usually focusing solely upon alcohol problems, often are limited by the small numbers of staff employed by any one employer.

The Alcohol Abuse Project of the United States Conference of Mayors undertook to implement an employee assistance program based upon a consortium model. Working with public interest groups in the District of Columbia, the Alcohol Abuse Project Staff of the USCM hoped to demonstrate the feasibility of implementing an employee assistance program by coordinating like groups of organizations with populations under 300.

#### Forming The Consortium

The Employee Assistance Program staff targeted for membership the seven major public interest groups located in the Washington, D.C., area. Entry was made at a personal level through the departments of personnel. This approach proved to be extremely workable as personnel officers frequently are called upon to respond to an organization's employee problems.

Upon gaining support of the personnel officer, meetings were arranged to include the personnel manager, a USCM Employee Assistance Program staff member, and the executive boards of each public interest group. Executive support was secured and program information was diffused downward from the top level of the organization to supervisory personnel, to professional staff, and to support staff.

#### Reaching The Employee: A Model For Success

Because the traditional line-staff organizational structure is either not present or not formalized in public interest groups, it was felt that the traditional program approach would not be effective with public interest group

personnel. Therefore, the program staff attempted informally to raise the consciousness of employees by using an educational model which projected an individual and personal appeal.

The above philosophy was followed throughout program implementation and coordination within each public interest group:

- Policy and program announcements signed by the organization's executive committee usually were enclosed with paychecks and distributed to all employees;
- Each employee was reached through a series of small, informal staff presentations which encouraged open discussion following a brief description of the program by program staff;
- Supervisory training sessions emphasized positive mental health and human responsibility instead of the traditional approach which focuses upon symptoms of the troubled employee and noncomitant supervisory responsibility;
- All consortium employees were invited to attend a series of bi-monthly luncheon seminars which addressed a variety of mental health and alcohol issues, and experts from appropriate fields were scheduled as guest speakers.

## Program Difficulties

Despite great flexibility in training scheduling, approximately 30 percent of the supervisory personnel did not receive training. Several factors contributed to this situation:

- Staff mobility and extensive travel interfered somewhat with seminar training scheduling.
- In-house communication systems also may have limited the potential success of training attendance. Some supervisors inadvertently were overlooked as a result of scheduling procedures.
- Cancellations made scheduling supervisory training sessions problematic.

An unanticipated problem was the large number of referrals (predominantly self-referrals) to the Employee Assistance Program during early months of operation. A penetration of 40 percent was evidenced within the first 80 days of the program although the program's scope of services was narrowly defined.

The program maintains only diagnostic and referral components. Staff makes interventions, identifies the nature of the problem, and refers the client to the appropriate treatment resource. In spite of the program's limitations, the case load became too great for the program staff to deal with effectively.

## Observations and Recommendations

**Observation** Utilizing the informal educational approach, the USCM Employee Assistance Program for Public Interest Groups achieved a penetration rate greater than 35 percent within the first 60 days of operation. Client contact was largely self-referral and involved a wide range of personal problems. Although many referrals resulted in detection of alcohol problems, the program was called upon to deal also with financial, sexual, geriatic, legal, and mental health problems.

**Recommendation** It is important that a wide range of community resources be identified for employee referral.

**Observation** Referrals included supervisory staff and supportive personnel. The program also provided assistance to members of employee's immediate families.

**Recommendation** Supportive and professional personnel and their families require employee assistance. The outreach and service mechanisms must be sufficient to respond to these needs.

**Observation** Critical to the success of an employee assistance program is the employees' assurance that the program exists to serve their personal needs and that the program will relate to each client as an individual.

**Recommendation** Service tailored to meet the needs of the individual should be emphasized as the program's primary objective.

**Observation** It is important that employee willingness to contact and use employee assistance not be underestimated.

**Recommendation** The program must establish a reputation of accessibility, confidentiality, and consistency among the population which it serves.

NATIONAL LEAGUE OF CITIES

UNITED STATES CONFERENCE OF MAYORS

EMPLOYEE ASSISTANCE PROGRAM
POLICY STATEMENTS DRAFT FOR EMPLOYEE REVIEW

We are establishing an Employee Assistance Program to aid our staff members who may have mental health problems, possible alcohol or other drug problems, financial worries or marital and family conflicts, when these types of problems may affect their job performance.

The program is not intended to intrude into the private lives of employees. However, the National League of Cities and the U.S. Conference of Mayors have a vital and legitimate concern for the general welfare of employees, and a specific interest in helping with personal problems which may impair an employee's ability to perform satisfactorily on the job.

Staff members are encouraged to come in voluntarily to seek information or advice at any time.

We recognize dependence on alcohol or other drugs as a treatable illness, rather than a moral issue. Given early diagnosis and treatment, the prognosis for recovery is excellent. We also know that other personal problems can seriously affect an individual's physical and mental health, and ultimately an employee's job performance.

We are committed to the maintenance of absolute confidentiality in the operation of the Employee Assistance Program. In addition to our commitment, confidentiality is guaranteed under federal regulations. Those regulations permit disclosure of information in a very few situations such as in a bona fide medical emergency, or if authorized by a court order. The regulations provide for stiff monetary penalties for their violation. The Employee Assistance Program will be designed to comply fully with the federal regulations on confidentiality.

Because of these regulations and our own personnel policies, any referrals to and business of the Employee Assistance Program cannot be made part of the employee's record.

The fact of referral of an employee for counseling, diagnosis or treatment, if necessary, shall not itself jeopardize an employees' job security or promotional opportunities. It is, however, expected that these referrals will result in improved employee job performance; should job performance still not meet expectations, the employee may be subject to termination or other appropriate disciplinary action.

Services of the Employee Assistance Program are available to families of employees. Staff may refer members of their immediate families who have possible alcohol, drug and mental health problems to the Employee Assistance Program Coordinator.

1620 Eye Street, N.W., Washington D. C. 20006 / 202-293-7300

Supervisors may make referrals to the program on the basis of deteriorating job performance, as defined to the employee in question.

Supervisors are not expected to diagnose specific behavioral problems. Supervisor orientation will cover the benefits of early intervention on behalf of the troubled employee, but at the same time will stress that referral to the porgram is to be made strictly on the basis of deteriorating job performance.

Supervisors who are unsure in their own minds about making a referral are encouraged to consult with the Employee Assistance Coordinator first, maintaining employee anonymity.

Employees remain ultimately responsible for their own job performance. The program is intended to help the troubled employee who seeks assistance back to full productivity.

As in other illness, the employee is responsible for treatment costs. The initial information, counseling and referral service provided by the program is free.

## *Appendix E*

Resolution adopted at the 44th Annual Meeting of the United States Conference of Mayors in Milwaukee, Wisconsin, July 1976.

WHEREAS, the U.S. Conference of Mayors has recognized the vast social and economic impact of alcohol abuse and alcoholism on our nation's cities; and

WHEREAS, it is the policy of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, to approach alcohol abuse and alcoholism from a comprehensive community care standpoint; and

WHEREAS, Mayors are in a prime position to assess the nature and extent of the alcohol problem in their communities, to identify the needs of their citizens, and to ensure the delivery of comprehensive quality services on the local level; and

WHEREAS, Mayors have begun to assume greater responsibility for alcoholism programs but are restricted in their efforts by the current economic conditions and insufficient federal appropriations for alcoholism programs,

NOW, THEREFORE, BE IT RESOLVED that the U.S. Conference of Mayors urges the Congress and the Administration to maintain the federal initiative for alcohol abuse programs so that units of local government can develop fully the capability to plan, coordinate, and ensure the implementation of comprehensive alcohol abuse programs on the local level; and

BE IT FURTHER RESOLVED that the U.S. Conference of Mayors urges the Congress to fund the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, at the full authorized levels; and

BE IT FURTHER RESOLVED that the U.S. Conference of Mayors urges the Congress and the Administration to encourage the states to make available to units of local government a substantial portion of their alcoholism formula grant allotment for the planning, coordination and implementation of comprehensive alcohol programs on the local level consistent with the state plan; and

BE IT FURTHER RESOLVED that the U.S. Conference of Mayors urges the Congress and the Administration to ensure greater local involvement in the formulation of national alcohol policies and programs by assuring membership of Mayors on the National Advisory Council on Alcohol Abuse and Alcoholism and the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism; and

BE IT FURTHER RESOLVED that the U.S. Conference of Mayors urges the Congress and the Administration to place emphasis on the development of new and effective prevention and education programs through collaborative efforts at the local, state, and national levels; and

BE IT FURTHER RESOLVED that the U.S. Conference of Mayors recommends that local governments be encouraged to create or designate an existing agency as a local comprehensive alcohol abuse and alcoholism planning unit to develop, coordinate, monitor, and evaluate the implementation of a local alcohol abuse plan.

## *Appendix F*

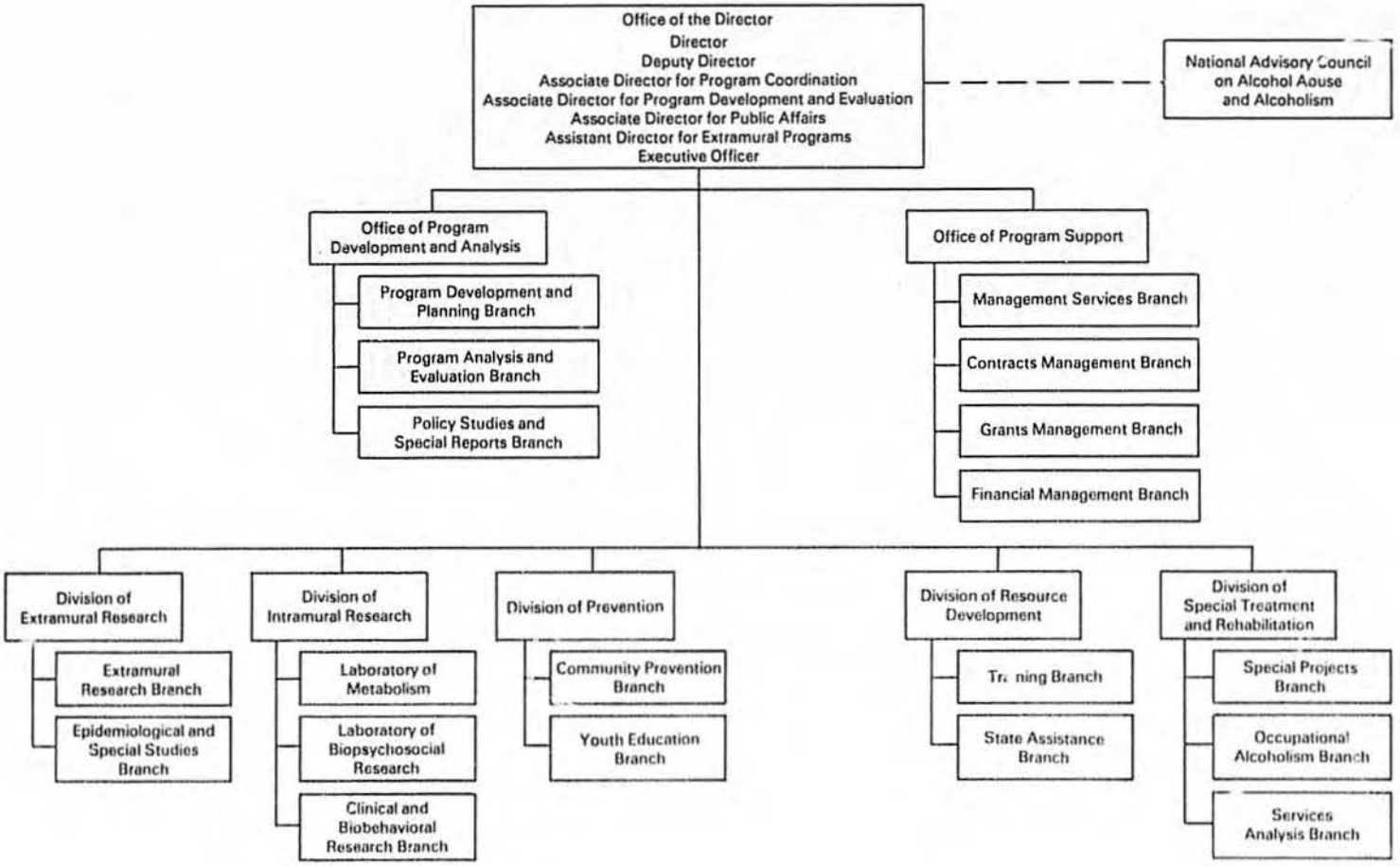
### RELATED UNITED STATES CONFERENCE OF MAYORS PUBLICATIONS

*Alcohol Abuse Programs in Cities: Strategies for Mayors,* May, 1976
*Employee Assistance Programs: Toward a More Productive Work Force,* August 1976
*Federal Legislation Relating to Alcohol Abuse and Alcoholism,* September 1976
*Prevention Programs: Roles and Models,* May, 1977

The above listed documents have been disseminated in the 86 cities which participated in the USCM Alcohol Abuse Survey. Copies should be available in the offices of: the Mayors, Criminal Justice, Health, and Manpower Planners, and other local officials.

## National Institute on Alcohol Abuse and Alcoholism

5600 Fishers Lane
Rockville, Maryland 20852
301/443-3306




*Appendix G*

## *Appendix H*

February 15, 1977

### COUNCIL OF STATE & TERRITORIAL ALCOHOLISM AUTHORITIES

### MEMBERSHIP LIST

State Alcohol Authorities

ALABAMA

Jerry Crowder, Director
State Alcoholism Program
Alabama Department of
Mental Health
145 Moulton Street
Montgomery, Alabama 36104
Telephone # 205-265-2301

ALASKA

Robert Cole, Coordinator
Office of Alcoholism
Division of Mental Health
Pouch H - 05F
Juneau, Alaska 99801
Telephone # 907-465-3020

ARIZONA

James F. Bailey, Chief
Community Programs
Arizona Department of
Health Services
Division of Behavioral Health
2500 East Van Buren Street
Phoenix, Arizona 85008
Telephone # 602-271-3438

ARKANSAS

Jess Wilson, Program Administrator
Office of Alcohol Abuse
and Alcoholism
Arkansas Department of Social and
Rehabilitative Services
1515 West 7th Street, Suite #202
Little Rock, Arkansas 72202
Telephone # 501-371-2003

CALIFORNIA

Ruth Saenz, Director
Office of Alcohol Program
Management
California Health & Welfare Agency
825 - 15th Street
Sacramento, California 95814
Telephone # 916-445-1940

COLORADO

Jeffry Kushner, Director
Colorado Alcohol & Drug Abuse
Division
Department of Health
4210 East 11th Avenue
Denver, Colorado 80220
Telephone # 303-388-6111

CONNECTICUT

Judith P. Wolfson, Executive Director
Connecticut State Alcohol Council
90 Washington Street
Hartford, Connecticut 06115
Telephone # 203-566-3464

DELAWARE

William B. Merrill, Chief
Bureau of Substanc[illegible]se
Division of Mental Hea[illegible]th
Governor Bacon Health Center
Delaware City, Delaware 19706
Telephone # 302-834-8850

DISTRICT OF COLUMBIA

District of Columbia Mental Health
Administration
1875 Connecticut Avenue, N.W.,
Rm. 822
Washington, D.C. 20009
Telephone # 202/629-3025

FLORIDA

George Clark, Administrator
Alcoholic Rehabilitation Program
Department of Health and
Rehabilitation Services
1309 Winewood Boulevard
Tallahassee, Florida 32301
Telephone # 904-488-9955

GEORGIA

John McGill, Director
Alcohol and Drug Abuse Section
Georgia Division of Mental Health
618 Ponce de Leon Avenue
Atlanta, Georgia 30308
Telephone # 404-894-4785

HAWAII

Timothy Wee, Acting Director
Hawaii Substance Abuse Agency
1270 Queen Emma Street, Room 404
Honolulu, Hawaii 96813
Telephone # 808-548-7655

IDAHO

Samuel Adams, Chief
Bureau of Substance Abuse
Idaho Health & Welfare Department
Statehouse
Boise, Idaho 83720
Telephone # 208-384-3920

ILLINOIS

Mrs. Roalda J. Alderman
Superintendent, Alcoholism Division
Illinois Department of Mental Health
and Developmental Disabilities
188 West Randolph Street
Room 1900
Chicago, Illinois 60601
Telephone # 312-793-2907

INDIANA

William F. Griglak
Assistant Commissioner
Indiana Division of Addiction Services
Five Indiana Square
Indianapolis, Indiana 46204
Telephone # 317-633-4477

IOWA

Jeff Voskans, Director
Iowa Division of Alcoholism
508 10th Street
5th Floor
Des Moines, Iowa 50319
Telephone # 515-281-4417

KANSAS

Curtis Hartenberger, Director
Alcohol & Drug Abuse Section
Kansas Department of Social and
Rehabilitation Services
Topeka State Hospital
Biddle Building
Topeka, Kansas 66606
Telephone # 913-296-3991

KENTUCKY

Michael Townsend
Acting Supervisor
Department of Human Resources
Bureau for Health Services
275 East Main Street
Frankfort, Kentucky 40601
Telephone # 502-564-7450